alternatives, and presents the measures we propose to minimize the burden on small entities.

B. Resource-Based Practice Expense Relative Value Units

Our proposal uses a methodology for implementing resource-based practice expense RVUs for each physician service. The methodology considers the staff, equipment, and supplies used in the provision of various medical and surgical services in various settings, including those that cannot be attributed to specific procedures. We are required to begin the transition to the new practice expense relative value units on January 1, 1999.

By law, the conversion to a resource-based determination for the payment of physician practice expenses must be budget-neutral. In other words, the total Medicare expenditures for calendar year 1999 must be the same as the amount that would have been paid under the prior method of paying practice expenses.

Each year since the fee schedule has been implemented, our actuaries have determined any adjustments needed to meet this requirement. A key component of the actuarial determination of budget neutrality involves estimating the impact of changes in the volume-and-intensity of physician services provided to Medicare beneficiaries as a result of the proposed changes.

In estimating the impacts of proposed changes under the physician fee schedule on the volume-and-intensity of services, the actuaries have historically used a model that assumes that 50 percent of the change in net revenue for a practice would be recouped. This does not mean that payments are reduced by 50 percent. In fact, payments have typically been reduced only a few percent or less. The actuaries also assume that there is no offsetting reduction in volume-and-intensity for physicians whose Medicare revenue increases.

Our actuaries have reviewed the literature and conducted data analysis of the volume-and-intensity response. For the purpose of establishing budget neutrality for the physician practice expense determination, the actuaries plan to use a model that assumes a 30 percent volume-and-intensity response to price reductions but no reduction in volume-and-intensity in response to a price increase. We plan to make the actuary's analysis of the volume-and-intensity response available soon. We expect it to be available on our homepage (www.hcfa.gov).

Using the revised actuarial model, achieving budget neutrality for the practice expense per hour method would require lowering physician payments in calendar year 1999 by 0.33 percent (1.31 percent cumulative from 1999–2002). The 0.33 percent volume-and-intensity adjustment results in a reduction in the 1999 physician CF of $0.1223. (The corresponding figures for the modified June 1997 proposed rule method would be 0.61 percent in 1999, 2.43 percent cumulative, and a $0.2248 reduction in the 1999 CF. The adjustments are larger due to the greater payment redistributions under this method.) We do not believe that we can use the Sustainable Growth Rate (SGR) mechanism alone, without the adjustment for volume-and-intensity for 1999, because any SGR adjustment would be in the future and the actuaries would not determine us to be in compliance with the statutory budget-neutrality requirement for 1999. To the extent that the volume-and-intensity response does not occur, the SGR system enacted as part of the BBA 1997 will return the volume-and-intensity adjustment in the form of higher future updates to the Medicare physician fee schedule conversion factor.

Table 8, ''Impact on Total Allowed Charges by Specialty of the Resource-Based Practice Expense Relative Value Units under the Practice Expense per Hour and Modified June 97 NPRM Methods'' shows the change in Medicare physician fees resulting from the practice expense per hour and the modified proposed rule methodologies discussed earlier in this proposed rule. The impact of the changes on the total revenue (Medicare and non-Medicare) for a given specialty is less than the impact displayed in Table 8 since physicians furnish services to both Medicare and non-Medicare patients.

The magnitude of the Medicare impact depends generally on the mix of services the specialty provides and the sites in which the services are performed. In general, those specialties that furnish more office-based services are expected to experience larger increases in Medicare payments than specialties that provide fewer office-based services. Table 8 also includes the impact on the conversion factor of the volume and intensity adjustments discussed above, but not the impact of the volume response on revenues.

TABLE 8.—IMPACT ON TOTAL ALLOWED CHARGES BY SPECIALTY OF THE RESOURCE-BASED PRACTICE EXPENSE RELATIVE VALUE UNITS UNDER THE PRACTICE EXPENSE PER HOUR (TOP-DOWN) AND MODIFIED JUNE 97 NPRM (BOTTOM-UP) METHODS (PERCENT CHANGE)

Specialty	Impact per year		Cumulative four year	
	PE/HR	Modified June 97 NPRM	PE/HR	Modified June 97 NPRM
M.D./D.O. Physicians:				
Anesthesiology	0	2	2	9
Cardiac Surgery	−4	−11	−14	−37
Cardiology	−3	−6	−13	−21
Clinics	−1	−1	−3	−5
Dermatology	6	8	27	36
Emergency Medicine	−3	−2	−13	−6
Family Practice	1	2	6	7
Gastroenterology	−4	−7	−14	−24
General Practice	1	1	3	5
General Surgery	−1	−4	−6	−16
Hematology/Oncology	1	4	2	15
Internal Medicine	0	0	1	−2
Nephrology	−1	−5	−5	−17
Neurology	0	−2	0	−7
Neurosurgery	−3	−7	−10	−27

TABLE 8.—IMPACT ON TOTAL ALLOWED CHARGES BY SPECIALTY OF THE RESOURCE-BASED PRACTICE EXPENSE RELATIVE VALUE UNITS UNDER THE PRACTICE EXPENSE PER HOUR (TOP-DOWN) AND MODIFIED JUNE 97 NPRM (BOTTOM-UP) METHODS (PERCENT CHANGE)—Continued

Specialty	Impact per year		Cumulative four year	
	PE/HR	Modified June 97 NPRM	PE/HR	Modified June 97 NPRM
Obstetrics/Gynecology	1	0	5	0
Ophthalmology	3	−1	11	−3
Orthopedic Surgery	0	−4	−1	−14
Other Physician*	0	0	0	2
Otolaryngology	1	2	6	8
Pathology	−3	1	−10	5
Plastic Surgery	1	−2	5	−9
Psychiatry	1	4	4	19
Pulmonary	−1	−3	−3	−10
Radiation Oncology	−3	3	−13	15
Radiology	−4	−3	−13	−13
Rheumatology	4	3	15	11
Thoracic Surgery	−4	−10	−13	−33
Urology	2	0	7	2
Vascular Surgery	−3	−6	−12	−23
Others:				
Chiropractic	0	4	−2	19
Nonphysician Practitioner	0	6	−1	26
Optometry	8	7	36	30
Podiatry	1	9	5	44
Suppliers	−5	9	−18	39

*Other physician includes allergy/immunology, oral surgery, physical medicine and rehabilitation, pediatrics, critical care, and hematology.

For several reasons, it is difficult to compare the impacts between the impacts in last year's June 18, 1997, proposed rule and the impacts in this proposed rule since BBA 1997 made several changes in physician payment. Although BBA 1997 delayed the initial implementation of the resource-based practice expense system until 1999, it created a down payment for the new system by increasing the practice expense payments for office visits in 1998 funded through decreases in the 1998 practice expense payments for certain procedures. For comparison purposes, the cumulative 4-year impacts displayed in Table 8 are shown below alongside the impacts in last year's June 1997 proposed rule adjusted for the down payment.

TABLE 9.—COMPARISON OF RESOURCE-BASED PRACTICE EXPENSE RELATIVE VALUE UNITS IMPACTS ON TOTAL ALLOWED CHARGES BY SPECIALTY WITH THE JUNE 97 NPRM NET OF THE DOWN PAYMENT (PERCENT CHANGE)

Specialty	June 97 NPRM	Impact of practice expense	June 97 NPRM	Modified June 97	PE/HR
M.D./D.O. Physicians:					
Anesthesiology	4.0	0.2	3.8	9	2
Cardiac Surgery	−32.0	−2.9	−30.0	−37	−14
Cardiology	−17.0	−1.1	−16.1	−21	−13
Clinics	−3.0	0.1	−3.1	−5	−3
Dermatology	18.0	0.6	17.2	36	27
Emergency Medicine	−2.0	−0.1	−1.9	−6	−13
Family Practice	12.0	2.0	9.8	7	6
Gastroenterology	−20.0	−0.9	−19.3	−24	−14
General Practice	9.0	1.5	7.4	5	3
General Surgery	−9.0	−0.2	−8.8	−16	−6
Hematology/Oncology	11.0	1.2	9.7	15	2
Internal Medicine	3.0	1.2	1.8	−2	1
Nephrology	−13.0	−0.7	−12.4	−17	−5
Neurology	−3.0	0.5	−3.4	−7	0
Neurosurgery	−21.0	−1.6	−19.7	−27	−10
Obstetrics/Gynecology	4.0	1.5	2.5	0	5
Ophthalmology	−11.0	−3.3	−8.0	−3	11
Orthopedic Surgery	−11.0	−0.9	−10.1	−14	−1
Other Physician*	4.0	0.2	3.8	2	0
Otolaryngology	7.0	0.5	6.5	8	6
Pathology	1.0	−0.6	1.6	5	−10
Plastic Surgery	−3.0	−0.3	−2.7	−9	5
Psychiatry	3.0	−0.1	3.1	19	4
Pulmonary	−6.0	0.1	−6.1	−10	−3

TABLE 9.—COMPARISON OF RESOURCE-BASED PRACTICE EXPENSE RELATIVE VALUE UNITS IMPACTS ON TOTAL ALLOWED CHARGES BY SPECIALTY WITH THE JUNE 97 NPRM NET OF THE DOWN PAYMENT (PERCENT CHANGE)—Continued

Specialty	June 97 NPRM	Impact of practice expense	June 97 NPRM	Modified June 97	PE/HR
Radiation Oncology	10.0	−0.4	10.4	15	−13
Radiology	−9.0	−0.3	−8.7	−13	−13
Rheumatology	15.0	2.0	12.8	11	15
Thoracic Surgery	−28.0	−2.3	−26.3	−33	−13
Urology	1.0	0.1	0.9	2	7
Vascular Surgery	−17.0	0.3	−17.2	−23	−12
Others:					
Chiropractic	14.0	−0.3	14.3	−2	−2
Nonphysician Practitioner	4.0	−0.7	4.8	−1	−1
Optometry	15.0	0.7	14.2	36	36
Podiatry	24.0	0.6	23.3	5	5
Suppliers	14.0	−0.8	14.9	−18	−18

*Other physician includes allergy/immunology, oral surgery, physical medicine and rehabilitation, pediatrics, critical care, and hematology.
Note: Columns do not add because figures are multiplicative. For example, the −30 June 97 NPRM net of the downpayment for cardiac surgery is derived from (1−(32/100))/(1−(2.9/100)).

In addition to the downpayment, other 1998 changes that significantly impacted Medicare physician fee schedule payments were the BBA 1997 move to a single CF and changes to the work RVUs contained in the October 31, 1997 final rule for the 1998 Medicare physician fee schedule. To provide a context for the current proposal, we are again publishing the impacts of these changes published in the October 1997 final notice (62 FR 59262). We are also expanding that table to separate the total change due to relative value units into change due to the downpayment and change due to work RVU revisions.

TABLE 10.—IMPACT ON 1998 ALLOWED CHARGES BY SPECIALTY OF THE SINGLE CONVERSION FACTOR, PRACTICE EXPENSE DOWN PAYMENT, AND WORK RVU CHANGES

[Percent change]

Specialty	Impact of the move to a single CF	Impact of the practice expense down payment	Impact of changes in work relative value units	Combined impact of the single CF, down payment, and work RVU
M.D./D.O. Physicians:				
Anesthesiology	1.2	0.2	0.7	2.1
Cardiac Surgery	−8.1	−2.9	2.3	−8.8
Cardiology	7.9	−1.1	−0.3	6.4
Clinics	4.5	0.1	−0.2	4.4
Dermatology	−4.8	0.6	−0.4	−4.6
Emergency Medicine	3.8	−0.1	−0.5	3.2
Family Practice	5.0	2.0	−0.6	6.4
Gastroenterology	8.5	−0.9	−0.4	7.1
General Practice	4.7	1.5	−0.3	6.0
General Surgery	−4.0	−0.2	2.0	−2.3
Hematology/Oncology	7.1	1.2	−0.3	8.0
Internal Medicine	6.4	1.2	−0.5	7.0
Nephrology	6.0	−0.7	−0.5	4.7
Neurology	7.9	0.5	−0.4	7.9
Neurosurgery	−5.7	−1.6	1.5	−5.9
Obstetrics/Gynecology	−2.3	1.5	1.5	0.6
Ophthalmology	−3.3	−3.3	0.7	−5.8
Orthopedic Surgery	−4.8	−0.9	1.8	−4.0
Other Physician*	6.4	0.2	−0.4	6.2
Otolaryngology	−0.1	0.5	0.1	0.5
Pathology	9.3	−0.6	−0.5	8.1
Plastic Surgery	−6.9	−0.3	2.0	−5.3
Psychiatry	9.0	−0.1	−0.6	8.2
Pulmonary	8.1	0.1	−0.5	7.7
Radiation Oncology	9.2	−0.4	−0.3	8.4
Radiology	9.0	−0.3	−0.4	8.2
Rheumatology	5.7	2.0	−0.6	7.2
Thoracic Surgery	−7.0	−2.3	2.2	−7.2
Urology	−3.3	0.1	0.3	−2.9
Vascular Surgery	−4.0	0.3	1.3	−2.6
Others:				
Chiropractic	9.3	−0.3	−0.5	8.4
Nonphysician Practitioner	5.1	−0.7	0.2	4.5
Optometry	5.7	0.7	−0.6	5.8

TABLE 10.—IMPACT ON 1998 ALLOWED CHARGES BY SPECIALTY OF THE SINGLE CONVERSION FACTOR, PRACTICE EXPENSE DOWN PAYMENT, AND WORK RVU CHANGES—Continued

[Percent change]

Specialty	Impact of the move to a single CF	Impact of the practice expense down payment	Impact of changes in work relative value units	Combined impact of the single CF, down payment, and work RVU
Podiatry	−5.2	0.6	0.2	−4.4
Suppliers	9.3	−0.8	−0.1	8.2

*Other physician includes allergy/immunology, oral surgery, physical medicine and rehabilitation, pediatrics, critical care, and hematology.

Finally, it is difficult to compare the impacts from last year's proposed rule to this proposed rule because of technical modifications to last year's methodology that are incorporated into this year's modified proposed rule approach. Technical modifications include elimination of last year's limits and caps on the CPEP estimates of clinical and administrative labor. We had received many comments (including from GAO) questioning this element of last year's methodology. The elimination of the caps partially explains the difference between the 9.8 percent increase for family practitioners last year (after netting out the effects of the downpayment) and the 7 percent increase that would occur with the modified proposed rule approach in this year's rule. It also partially explains the increase in payments for dermatologists from last year's 17.2 percent (netting out the effect of the downpayment) to the 36 percent increase which would occur under the modified proposed rule approach in this year's rule.

Table 11. ''Total Payment for Selected Procedures,'' shows the percentage change in total payment allowances (in 1998 dollars) between the current and the fully phased-in resource-based practice expense system for certain high volume procedures.

TABLE 11.—TOTAL PAYMENT FOR SELECTED PROCEDURES

Code	Mod	Description	Current non-facility	Resource based non-facility	Non-facility percent change	Current facility	Resource based facility
11721		Debride nail, 6 or more	$39.81	$31.69	−20	$29.91	$30.90
17000		Destroy benign/premal lesion	36.69	52.12	42	28.99	42.82
27130		Total hip replacement	NA	NA	NA	1,656.80	1,383.69
27236		Repair of thigh fracture	NA	NA	NA	1,244.62	1,065.87
27244		Repair of thigh fracture	NA	NA	NA	1,230.38	1,083.55
27447		Total knee replacement	NA	NA	NA	1,771.16	1,454.99
33533		CABG, arterial, single	NA	NA	NA	2,107.91	1,764.20
35301		Rechanneling of artery	NA	NA	NA	1,262.70	1,069.02
43239		Upper GI endoscopy, biopsy	228.81	241.66	6%	211.20	140.58
45378		Diagnostic colonoscopy	290.30	292.34	1	288.10	208.17
45385		Colonoscopy, lesion removal	443.89	375.88	−15	414.17	277.71
66821		After cataract laser surgery	187.65	192.66	3	187.65	184.24
66984		Remove cataract, insert lens	NA	NA	NA	795.26	677.97
67210		Treatment of retinal lesion	686.27	639.55	−7	520.81	596.86
71010	26	Chest x-ray	9.36	8.49	−9	9.36	8.49
71020		Chest x-ray	34.55	27.71	−20	34.55	27.71
71020	26	Chest x-ray	11.44	10.36	−9	11.44	10.36
77430		Weekly radiation therapy	188.62	171.24	−9	188.62	171.24
78465		Heart image (3D) multiple	514.68	397.85	−23	514.68	397.85
88305		Tissue exam by pathologist	65.95	66.01	0	65.95	66.01
88305	26	Tissue exam by pathologist	46.14	37.58	−19	46.14	37.58
90801		Psy dx interview	122.08	135.64	11	122.08	134.08
90806		Psytx, office (45–50)	80.95	86.09	6	80.95	82.49
90807		Psytx, office (45–50) w/e&m	90.03	98.66	10	90.03	94.67
90862		Medication management	47.37	46.51	−2	47.37	45.88
90921		ESRD related services, month	235.86	226.79	−4	235.86	226.79
90935		Hemodialysis, one evaluation	NA	NA	NA	93.87	64.99
92004		Eye exam, new patient	77.83	113.47	46	67.37	87.79
92012		Eye exam established pt	39.42	68.43	74	31.35	35.68
92014		Eye exam & treatment	57.55	82.39	43	47.65	58.21
92980		Insert intracoronary stent	NA	NA	NA	1,142.75	899.31
92982		Coronary artery dilation	NA	NA	NA	857.33	680.44
93000		Electrocardiogram, complete	28.83	15.87	−45	28.83	15.87
93010		Electrocardiogram report	11.96	8.45	−29	11.96	8.45
93015		Cardiovascular stress test	116.95	98.79	−16	116.95	98.79
93307		Echo exam of heart	215.85	103.39	−52	215.85	103.39
93307	26	Echo exam of heart	70.94	50.80	−28	70.94	50.80
93510	26	Left heart catheterization	266.37	222.31	−17	266.37	222.31
98941		Chiropractic manipulation	32.87	32.55	−1	27.55	28.26
99202		Office/outpatient visit, new	50.15	71.19	42	39.69	49.05
99203		Office/outpatient visit, new	68.93	100.60	46	56.82	73.17

TABLE 11.—TOTAL PAYMENT FOR SELECTED PROCEDURES—Continued

Code	Mod	Description	Current non-facility	Resource based non-facility	Non-facility percent change	Current facility	Resource based facility
99204		Office/outpatient visit, new	102.50	141.83	38	84.53	105.52
99205		Office/outpatient visit, new	128.35	173.06	35	108.72	135.83
99211		Office/outpatient visit, est	14.16	17.96	27	9.94	12.22
99212		Office/outpatient visit, est	27.61	32.09	16	21.01	25.83
99213		Office/outpatient visit, est	39.42	43.39	10	30.61	35.86
99214		Office/outpatient visit, est	59.39	68.39	15	47.65	57.82
99215		Office/outpatient visit, est	93.67	101.73	9	76.06	90.38
99221		Initial hospital care	NA	NA	NA	69.84	67.71
99222		Initial hospital care	NA	NA	NA	113.45	108.20
99223		Initial hospital care	NA	NA	NA	144.98	147.84
99231		Subsequent hospital care	NA	NA	NA	36.57	32.35
99232		Subsequent hospital care	NA	NA	NA	53.64	52.07
99233		Subsequent hospital care	NA	NA	NA	74.65	73.72
99236		Observ/hosp same date	NA	NA	NA	188.78	207.45
99238		Hospital discharge day	NA	NA	NA	63.24	64.40
99239		Hospital discharge day	NA	NA	NA	79.05	86.11
99241		Office consultation	47.95	50.20	5	36.21	38.46
99242		Office consultation	74.95	86.81	16	60.82	69.87
99243		Office consultation	97.12	111.83	15	79.33	92.28
99244		Office consultation	135.96	154.79	14	113.40	132.87
99245		Office consultation	183.26	196.49	7	152.26	174.83
99251		Initial inpatient consult	NA	NA	NA	49.72	39.47
99252		Initial inpatient consult	NA	NA	NA	75.59	72.93
99253		Initial inpatient consult	NA	NA	NA	99.75	98.25
99254		Initial inpatient consult	NA	NA	NA	136.88	137.30
99255		Initial inpatient consult	NA	NA	NA	185.53	186.50
99261		Follow-up inpatient consult	NA	NA	NA	27.34	25.99
99262		Follow-up inpatient consult	NA	NA	NA	46.94	47.05
99263		Follow-up inpatient consult	NA	NA	NA	68.77	67.16
99282		Emergency dept visit	NA	NA	NA	33.55	24.76
99283		Emergency dept visit	NA	NA	NA	61.16	52.53
99284		Emergency dept visit	NA	NA	NA	93.48	81.10
99285		Emergency dept visit	NA	NA	NA	147.34	125.14
99291		Critical care, first hour	191.07	189.23	−1	191.07	191.13
99292		Critical care, addl 30 min	91.86	96.23	5	91.86	96.62
99301		Nursing facility care	NA	NA	NA	57.98	65.81
99302		Nursing facility care	NA	NA	NA	73.98	87.08
99303		Nursing facility care	NA	NA	NA	105.04	107.40
99311		Nursing facility care, subseq	NA	NA	NA	33.76	34.61
99312		Nursing facility care, subseq	NA	NA	NA	49.78	53.24
99313		Nursing facility care, subseq	NA	NA	NA	66.12	73.34
99348		Home visit, estab patient	63.30	65.30	3	63.30	74.41
99350		Home visit, estab patient	132.39	148.19	12	132.39	141.51

BBA 1997 requires that we consider the geographic impacts of the new payment system. The following table displays the impact of the practice expense per hour methodology by Medicare payment locality, including the volume-and-intensity increase and corresponding conversion factor adjustment discussed earlier.

TABLE 12.—IMPACT OF PRACTICE EXPENSE PER HOUR METHODOLOGY ON TOTAL ALLOWED CHARGES BY MEDICARE LOCALITY

[Percent change]

Locality	State	Impact per year	Cumulative four year impact
All	Alabama	−0.3	−1.0
All	Alaska	0.1	0.5
All	Arizona	0.1	0.3
All	Arkansas	−0.1	−0.3
Marin/Napa/Solano	California	0.8	3.4
San Francisco	California	0.9	3.5
San Mateo	California	0.6	2.5
Oakland/Berkeley	California	0.3	1.1
Santa Clara	California	0.3	1.0
Rest of California	California	0.2	0.8

TABLE 12.—IMPACT OF PRACTICE EXPENSE PER HOUR METHODOLOGY ON TOTAL ALLOWED CHARGES BY MEDICARE LOCALITY—Continued

[Percent change]

Locality	State	Impact per year	Cumulative four year impact
Ventura	California	0.3	1.4
Los Angeles	California	0.5	1.9
Anaheim/Santa Ana	California	0.6	2.6
Rest of California	California	0.7	3.0
All	Colorado	0.3	1.1
All	Connecticut	0.1	0.3
All	Delaware	−0.2	−0.7
All	District of Columbia	−0.1	−0.3
Ft Lauderdale	Florida	0.5	2.1
Miami	Florida	−0.3	−1.3
Rest of Florida	Florida	0.0	0.0
Atlanta	Georgia	−0.3	−1.2
Rest of Georgia	Georgia	−0.1	−0.4
All	Hawaii	0.9	3.7
All	Idaho	0.1	0.5
East St Louis	Illinois	0.1	0.3
Suburban Chicago	Illinois	0.0	0.1
Chicago	Illinois	−0.3	−1.1
Rest of Illinois	Illinois	−0.2	−0.6
All	Indiana	−0.2	−0.7
All	Iowa	0.2	0.9
All	Kansas	−0.1	−0.2
All	Kentucky	−0.2	−0.8
New Orleans	Louisiana	0.0	0.1
Rest of Louisiana	Louisiana	−0.1	−0.5
Southern Maine	Maine	−0.1	−0.4
Rest of Maine	Maine	0.2	0.7
Balto/Surr Ctys	Maryland	−0.3	−1.2
Rest of Maryland	Maryland	−0.1	−0.6
Boston	Massachusetts	0.2	1.0
Rest of Massachusetts	Massachusetts	0.2	1.0
Detroit	Michigan	−0.3	−1.2
Rest of Michigan	Michigan	−0.2	−1.0
All	Minnesota	−0.2	−0.9
All	Mississippi	−0.2	−0.9
Metro Kansas City	Missouri	−0.6	−2.2
Rest of Missouri	Missouri	0.1	0.3
St Louis	Missouri	−0.1	−0.5
Rest of Missouri	Missouri	0.3	1.2
All	Montana	0.1	0.4
All	Nebraska	0.1	0.4
All	Nevada	−0.3	−1.2
All	New Hampshire	0.2	0.8
Northern New Jersey	New Jersey	−0.1	−0.4
Rest of New Jersey	New Jersey	−0.1	−0.5
All	New Mexico	0.3	1.3
Rest of New York	New York	−0.2	−0.6
Manhattan	New York	0.3	1.1
NYC Suburbs/LI	New York	−0.1	−0.5
Poughkpsie/N NYC	New York	0.3	1.2
Queens	New York	0.3	1.0
All	North Carolina	0.0	0.0
All	North Dakota	−0.3	−1.2
All	Ohio	−0.1	−0.2
All	Oklahoma	0.1	0.3
Portland	Oregon	0.0	0.0
Rest of Oregon	Oregon	0.5	2.1
Philadelphia	Pennsylvania	−0.2	−0.8
Rest of Pennsylvania	Pennsylvania	−0.1	−0.4
All	Puerto Rico	0.8	3.2
All	Rhode Island	0.0	0.2
All	South Carolina	0.0	0.0
All	South Dakota	−0.3	−1.1
All	Tennessee	−0.3	−1.0
Brazoria	Texas	0.8	3.4
Dallas	Texas	−0.1	−0.4
Galveston	Texas	0.1	0.6
Houston	Texas	−0.3	−1.2

TABLE 12.—IMPACT OF PRACTICE EXPENSE PER HOUR METHODOLOGY ON TOTAL ALLOWED CHARGES BY MEDICARE LOCALITY—Continued

[Percent change]

Locality	State	Impact per year	Cumulative four year impact
Beaumont	Texas	−0.4	−1.8
Fort Worth	Texas	−0.2	−0.8
Austin	Texas	−0.4	−1.5
Rest of Texas	Texas	0.0	−0.2
All	Utah	0.3	1.0
All	Vermont	0.5	2.1
All	Virgin Islands	0.6	2.6
All	Virginia	0.1	0.5
Seattle (King Co)	Washington	0.1	0.3
Rest of Washington	Washington	0.2	0.8
All	West Virginia	−0.1	−0.4
All	Wisconsin	−0.1	−0.6
All	Wyoming	0.5	2.1

BBA 1997 requires that we consider the impacts of the new system on urban and rural localities. The geographic payment areas we use for payment under the physician fee schedule do not follow urban and rural configurations. For example, in 34 States (plus the District of Columbia, Puerto Rico, and the Virgin Islands) the payment areas are statewide; that is, the Medicare payment is the same in both urban and rural areas. In those States, there would be no differential impact of this proposal on urban and rural areas. Since our payment areas do not track urban and rural locations, our claims payment system does not distinguish between urban and rural locations, and we do not have data easily available to undertake an urban-rural impact analysis. We do not believe that this proposal will have much urban-rural impact, particularly since 34 States (plus the District of Columbia, Puerto Rico, and the Virgin Islands) have statewide payment areas. Any urban-rural impact should largely be explained by differences in the mix and site of services among urban and rural localities.

BBA 1997 requires us to consider impact projections that compare new proposed payment amounts to data on actual physician practice expenses. We have satisfied this requirement by basing the new proposed payments amounts on actual physician practice expense data.

C. Medical Direction for Anesthesia Services

We are proposing to revise the conditions for payment of medical direction performed by a physician. Thus, we are proposing to revise our regulations in § 415.10 (Conditions for payment: Anesthesiology services) to state that we will pay a physician for medical direction of anesthesia services, for a single case or for two, three, or four concurrent cases if the services meet the condition in § 415.102(a) (Conditions for fee schedule payment for physician services to beneficiaries in providers). This proposal has no payment implications. The payment rate for medical direction, which is included in the statute, would not change.

D. Separate Payment for Physician Interpretation of an Abnormal Papanicolaou Smear

Under our proposed policy, we would allow separate payment, under the physician fee schedule, for the physician interpretation of Pap smears in all sites. Currently, separate payment to physicians is limited to services furnished for hospital inpatients. We estimate that there would be a minimal cost impact in payments under the physician fee schedule for this change in Pap smear interpretations. This cost would be more than offset by the savings resulting from the change in the calculation of the median for payment of drugs and biologicals.

E. Rebasing and Revising the Medicare Economic Index

There is negligible impact on Medicare expenditures as a result of this change.

F. Payment for Nurse Midwives' Services

The provision for nurse midwives' services would place into regulations text a provision of OBRA 1993 that eliminates the limitation on coverage of services furnished outside the maternity cycle by nurse midwives. This provision has been implemented previously through program instructions; therefore, this change in the regulations text would have no impact.

G. BBA 1997 Provisions Included in This Proposed Rule

The following four provisions of BBA 1997 are included in this proposed rule. This proposed rule conforms the regulations text to the BBA 1977 provisions. The following table provides the cost and savings estimates (in millions of dollars) for these provisions for the fiscal years shown:

Provision Section	Subject	1999	2000	2001	2002	2003
4511	Nurse practitioners and Clinical Nurse Specialists.	290	330	370	440	490
4512	Physician Assistants	60	60	70	90	100
4541	Outpatient Physical Therapy	−130	−190	−200	−230	−250
4556	Drugs	−60	−70	−70	−80	−80

1. Payment for Services of Certain Nonphysician Practitioners and Services Furnished Incident to Their Professional Services

Sections 4511 and 4512 of BBA 1997 provide for the expanded coverage of nurse practitioner, clinical nurse specialist, and physician assistant services. This provision is self-implementing. This proposed rule changes the regulations text to conform to the BBA 1997 provisions. We are taking this opportunity to clarify the following two existing issues unrelated to the BBA 1997 provisions for nonphysician practitioners.

- Proposing a revised definition of physician collaboration for nurse practitioners and clinical nurse specialists.
- Modifying the qualifications of physicians assistants to recognize orthopedic physician assistants as physician assistants.

The impact of the BBA 1997 provision is shown in the table above (a combination of sections 4511 and 4512 of BBA 1997). The proposals being made in this proposed rule would have negligible budgetary impact.

2. Payment for Outpatient Rehabilitation Services

Sections 4541(a)(2)(B) and 4541(a)(3) of BBA 1997 change the payment of outpatient rehabilitation services from cost-based to a payment system based on the physician fee schedule. These provisions are self-implementing. The impact of this proposal is shown in the table above. The regulatory changes are to conform our regulations to the provisions of BBA 1997.

The following proposals are being made in this proposed rule to furnish information for identification of the outpatient rehabilitation services and for administrative purposes:

- Specifying HCPCS as the coding system for rehabilitation services since it is used by the fee schedule in section 1848 of the Act.
- Providing for discipline-specific modifiers to be used in coding services.
- Providing for a code for nursing services performed in CORFs.

These proposals will have a negligible impact.

We are providing some additional impact information regarding this BBA 1997 provision. There are several different types of providers that will be affected by this BBA 1997 provision. They are SNFs, outpatient rehabilitation facilities, and hospital outpatient departments. There about 15,000 SNFs, 2,500 outpatient rehabilitation facilities, and about 5,600 outpatient hospital facilities. In estimating the impacts of this provision on these entities, we determined that the services that would be affected by these changes account for about 5 percent of facility payments in these providers.

We realize there may be an impact on small rural hospitals; however, we have been unable to assess this impact because we do not have the data to make this analysis. Also, data that would identify the extent to which these services are currently being furnished in small rural hospitals to serve as the baseline for comparing impact of the legislative changes are not available. In addition, we do not maintain data that identify services furnished under the physician fee schedule in areas where rural hospitals are located. Although there are localities designated for payment purposes, there is very little correlation between the payment localities (most of which are state-wide) and areas where small rural hospitals are located.

3. Payment for Drugs and Biologicals

The impact of this BBA 1997 provision is shown in the table above. This proposed rule modifies the current regulatory language regarding drug reimbursement to conform to the BBA 1997 changes. The proposal in this proposed rule to modify the method used to calculate the median to include the brand name of the drug is not related to the BBA 1997 drug provision but would have a slight program savings. This is offset by the cost for the proposal to provide a separate payment for the interpretation of an abnormal Pap smear, which was described above.

4. Private Contracting with Medicare Beneficiaries

We anticipate that there would be a negligible impact on Medicare trust fund payments as a result of the regulation that implements the law. The program impact of the provision when it was assessed in the legislative process was negligible and vanished under our rounding rules. The impact on beneficiaries, physicians, and practitioners is impossible to assess in any quantitative way.

Specifically, beneficiaries who have had difficulty in finding physicians or practitioners to furnish services because the physicians or practitioners were dissatisfied with the Medicare payment rates may find it easier to acquire care. On the other hand, beneficiaries who cannot afford to privately contract with physicians or practitioners who opt-out of Medicare may have more limited access to care as they try to seek care from reduced numbers of physicians and practitioners who will accept Medicare payment rules.

Physicians and practitioners who opt-out of Medicare may see increased incomes as a result of their ability to charge without regard to the Medicare limiting charge. However, to the extent that beneficiaries cease to seek treatment from them because they have opted-out of Medicare, their incomes may decline. Moreover, organizations to which physicians and practitioners had reassigned Medicare benefits may cease their contracts with them if they opt-out since they could no longer be paid by Medicare for the physician or practitioner service. Managed care plans that have a contract with Medicare may cease their contractual arrangement with physicians and practitioners who opt-out of Medicare since the plan cannot pay for any of their services to Medicare beneficiaries and, hence, their services no longer offer access to care under the plan. Similarly, insurance plans other than Medicare can choose to not pay for the services provided to any of their enrollees by physicians and practitioners who opt-out of Medicare, causing the physicians and practitioners who opt-out further loss of income.

H. Impact on Beneficiaries

Although changes in physician payments when the physician fee schedule was implemented in 1992 were large, we detected no problems with beneficiary access to care. Because there is a 4-year transition to the proposed values, we anticipate a minimal impact on beneficiaries.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Rural areas, X-rays.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare,

Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 415

Health facilities, Health professions, Medicare Reporting and recordkeeping requirements.

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare.

42 CFR Part 485

Grant programs-health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, 42 CFR chapter IV would be amended as follows:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

A. Part 405 is amended as set forth below:

1. A new subpart D, consisting of §§ 405.400, 405.405, 405.410, 405.415, 405.420, 405.425, 405.430, 405.435, 405.440, 405.445, 405.450, and 405.455 is added to read as follows:

Subpart D—Private Contracts

Secs.

Subpart D—Private Contracts

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§ 405.400 Definitions.

For purposes of this subpart, the following definitions apply:

Beneficiary means an individual who is enrolled in Part B of Medicare.

Emergency care services means services furnished to an individual for treatment of an ''emergency medical condition'' as that term is defined in § 489.24 of this chapter.

Legal representative means an individual who has been appointed as the beneficiary's legal guardian under State law or who has been granted a power of attorney from the beneficiary, which power of attorney is sufficient to permit the individual to enter into private contracts on the beneficiary's behalf.

Opt-out means the status of meeting the conditions specified in § 405.410.

Opt-out period means the 2-year period beginning on the effective date of the affidavit as specified by § 405.410(c)(1) or § 405.410(c)(2), as applicable.

Participating physician means a ''physician'' as defined in this section who has signed an agreement to participate in Part B of Medicare.

Physician means a doctor of medicine or a doctor of osteopathy who is currently licensed as that type of doctor in each State in which he or she furnishes services to patients.

Practitioner means a physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical psychologist, or clinical social worker, who is currently legally authorized to practice in that capacity by each State in which he or she furnishes services to patients or clients.

Private contract means a document that meets the criteria specified in § 405.415.

Properly opt-out means to complete, without defect, the requirements for opt-out as specified in § 405.410.

Properly terminate opt-out means to complete, without defect, the requirements for terminating opt-out as specified in § 405.445.

Urgent care services means services furnished to an individual who requires services to be furnished within 12 hours in order to avoid the likely onset of an emergency medical condition.

§ 405.405 General rules.

(a) A physician or practitioner may enter into one or more private contracts with Medicare beneficiaries for the purpose of furnishing items or services that would otherwise be covered by Medicare, provided the conditions of this subpart are met.

(b) A physician or practitioner who enters into at least one private contract with a Medicare beneficiary under the conditions of this subpart, and who submits one or more affidavits in accordance with this subpart, opts-out of Medicare for a 2-year period. The physician's or practitioner's opt-out may be renewed for subsequent 2-year periods.

(c) Both the private contracts described in paragraph (a) of this section and the physician's or practitioner's opt-out described in paragraph (b) of this section are null and void if the physician or practitioner fails to properly opt-out in accordance with the conditions of this subpart, or fails to remain in compliance with the conditions of this subpart during the opt-out period.

(d) Services furnished under private contracts meeting the requirements of this subpart are not covered services under Medicare, and no Medicare payment would be made for such services either directly or indirectly.

§ 405.410 Conditions for properly opting-out of Medicare.

The following conditions must be met for a physician or practitioner to properly opt-out of Medicare:

(a) Each private contract between a physician or a practitioner and a Medicare beneficiary must meet the specifications of § 405.415.

(b) The physician or practitioner must submit to each Medicare carrier with which he or she files claims an affidavit that meets the specifications of § 405.420.

(c) A nonparticipating physician or a practitioner may opt-out of Medicare at any time in accordance with the following:

(1) The 2-year opt-out period begins the date the affidavit meeting the requirements of § 405.420 is signed, provided the affidavit is timely filed (that is, within 10 days after the first private contract is entered into).

(2) If the physician or practitioner does not timely file any required affidavit, the 2-year opt-out period begins when the last such affidavit is filed. Any private contract entered into before the last required affidavit is filed becomes effective upon the filing of the last required affidavit and the furnishing of any items or services to a Medicare beneficiary under such contract before the last required affidavit is filed is subject to standard Medicare rules.

(d) A participating physician may properly opt-out of Medicare at the beginning of any calendar quarter, provided that the affidavit described in § 405.420 is submitted to the participating physician's Medicare carriers at least 30 days before the beginning of the selected calendar quarter. A private contract entered into before the beginning of the selected calendar quarter becomes effective at the beginning of the selected calendar quarter and the furnishing of any items or services to a Medicare beneficiary under such contract before the beginning of the selected calendar quarter is subject to standard Medicare rules.

§ 405.415 Requirements of the private contract.

A private contract under this subpart must:

(a) Be in writing and in print sufficiently large to ensure that beneficiaries are able to read the contract.

(b) State whether the physician or practitioner is excluded from Medicare under section 1128 of the Social Security Act.

(c) State that the beneficiary or his or her legal representative accepts full responsibility for payment of the physician's or practitioner's charge for the services furnished.

(d) State that the beneficiary or his or her legal representative understands that Medicare limits do not apply to what the physician or practitioner may charge for items or services furnished by the physician or practitioner.

(e) State that the beneficiary or his or her legal representative agrees not to submit a claim to Medicare or to ask the physician or practitioner to submit a claim to Medicare.

(f) State that the beneficiary or his or her legal representative understands that Medicare payment will not be made for any items or services furnished by the physician or practitioner that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

(g) State that the beneficiary or his or her legal representative enters into this contract with the knowledge that he or she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare.

(h) State the expected effective date and expected expiration date of the opt-out period.

(i) State that the beneficiary or his or her legal representative understands that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

(j) Be signed by the beneficiary or his or her legal representative and by the physician or practitioner.

(k) Not be entered into by the beneficiary or by the beneficiary's legal representative during a time when the beneficiary requires emergency care services or urgent care services. (However, a physician or practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with § 405.440.)

(l) Be provided (a photocopy is permissible) to the beneficiary or to his or her legal representative before items or services are furnished to the beneficiary under the terms of the contract.

(m) Be retained (original signatures of both parties required) by the physician or practitioner for the duration of the opt-out period.

(n) Be made available to HCFA upon request.

(o) Be entered into for each opt-out period.

§ 405.420 Requirements of the opt-out affidavit.

An affidavit under this subpart must:

(a) Be in writing and be signed by the physician or practitioner.

(b) Contain the physician's or practitioner's full name, address, telephone number, national provider identifier (NPI) or billing number, if one has been assigned, uniform provider identification number (UPIN) if one has been assigned, or, if neither an NPI nor a UPIN has been assigned, the physician's or practitioner's tax identification number (TIN).

(c) State that, during the opt-out period, the physician or practitioner will provide services to Medicare beneficiaries only through private contracts that meet the criteria of paragraph § 405.415 for services that, except for their provision under a private contract, would have been Medicare-covered services.

(d) State that the physician or practitioner will not submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt-out period, nor will the physician or practitioner permit any entity acting on his or her behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary, except as specified in § 405.440.

(e) State that, during the opt-out period, the physician or practitioner understands that he or she may receive no direct or indirect Medicare payment for services that he or she furnishes to Medicare beneficiaries with whom he or she has privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under a Medicare+Choice plan.

(f) State that a physician or practitioner who opts-out of Medicare acknowledges that, during the opt-out period, his or her services are not covered under Medicare and that no Medicare payment may be made to any entity for his or her services, directly or on a capitated basis.

(g) State a promise by the physician or practitioner to the effect that, during the opt-out period, the physician or practitioner agrees to be bound by the terms of both the affidavit and the private contracts that he or she has entered into.

(h) Acknowledge that the physician or practitioner recognizes that the terms of the affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by the physician or practitioner during the opt-out period (except for emergency or urgent care services furnished to the beneficiaries with whom he or she has not previously privately contracted) without regard to any payment arrangements the physician or practitioner may make.

(i) With respect to a physician who has signed a Part B participation agreement, acknowledge that such agreement terminates on the effective date of the affidavit.

(j) Acknowledge that the physician or practitioner understands that a beneficiary who has not entered into a private contract and who requires emergency or urgent care services may not be asked to enter into a private contract with respect to receiving such services and that the rules of § 405.440 apply if the physician furnishes such services.

(k) Be submitted to:

(1) Each Medicare carrier to which the physician or practitioner has submitted claims within the past 2 years.

(2) To any additional carriers to which claims would be sent on the date the first private contract is entered into, in accordance with Medicare instructions on claim submission then in effect.

(l) With respect to nonparticipating physicians and with respect to practitioners, be submitted within 10 days after the nonparticipating physician or practitioner signs his or her first private contract with a Medicare beneficiary.

(m) With respect to participating physicians, be submitted in accordance with § 405.410(d).

§ 405.425 Effects of opting-out of Medicare.

If a physician or practitioner opts-out of Medicare in accordance with this subpart for the 2-year period for which the opt-out is effective, the following results obtain:

(a) Except as provided in § 405.440, no payment may be made directly by Medicare or by any Medicare+Choice plan to the physician or practitioner or to any entity to which the physician or practitioner reassigns his right to receive payment for services.

(b) The physician or practitioner may not furnish any item or service that would otherwise be covered by

Medicare (except for emergency or urgent care services) to any Medicare beneficiary except through a private contract that meets the requirements of this subpart.

(c) The physician or practitioner is not subject to the requirement to submit a claim for items or services furnished to a Medicare beneficiary, as specified in § 424.5(a)(6) of this chapter, except as provided in § 405.440.

(d) The physician or practitioner is prohibited from submitting a claim to Medicare for items or services furnished to a Medicare beneficiary except as provided in § 405.440.

(e) In the case of a physician, he or she is not subject to the limiting charge provisions of § 414.48 of this chapter.

(f) The physician or practitioner is not subject to the prohibition-on-reassignment provisions of § 414.80 of this chapter.

(g) In the case of a practitioner, he or she is not prohibited from billing or collecting amounts from beneficiaries (as provided in 42 U.S.C. 1395u(b)(18)(B)).

(h) The death of a beneficiary who has entered into a private contract (or whose legal representative has done so) does not invoke § 424.62 or § 424.64 of this chapter with respect to the physician or practitioner with whom the beneficiary (or legal representative) has privately contracted.

(i) The physician or practitioner may order, certify the need for, or refer a beneficiary for Medicare-covered items and services, provided the physician or practitioner is not paid, directly or indirectly, for such ordering, certifying, or referring services.

§ 405.430 Failure to properly opt-out.

(a) A physician or practitioner fails to properly opt-out if—

(1) Any private contract between the physician or practitioner and a Medicare beneficiary, that was entered into before the affidavit described in § 405.420 was filed, does not meet the specifications of § 405.415; or

(2) He or she fails to submit the affidavit(s) in accordance with § 405.420.

(b) If a physician or practitioner fails to properly opt-out in accordance with paragraph (a) of this section, the following results obtain:

(1) All of the private contracts between the physician or practitioner and Medicare beneficiaries are deemed null and void.

(2) The physician's or practitioner's attempt to opt-out of Medicare is nullified.

(3) The physician or practitioner must submit claims to Medicare for all Medicare-covered items and services furnished to Medicare beneficiaries.

(4) The physician is subject to the limiting charge provisions of § 414.48 of this chapter.

(5) The practitioner may not reassign any claim except as provided in § 424.80 of this chapter.

(6) The practitioner may neither bill nor collect an amount from the beneficiary except for applicable deductible and coinsurance amounts.

(7) The physician or practitioner may make another attempt to properly opt-out at any time.

§ 405.435 Failure to maintain opt-out.

(a) A physician or practitioner fails to maintain opt-out under this subpart if, during the opt-out period—

(1) He or she knowingly and willfully—

(i) Submits a claim for Medicare payment (except as provided in § 405.440); or

(ii) Receives Medicare payment directly or indirectly for Medicare-covered services furnished to a Medicare beneficiary (except as provided in § 405.440).

(2) He or she enters into private contracts with Medicare beneficiaries for the purpose of furnishing items and services that would otherwise be covered by Medicare, but such contracts fail to meet the specifications of § 405.415; or

(3) He or she fails to comply with the provisions of § 405.440 regarding billing for emergency care services or urgent care services; or

(4) He or she fails to retain a copy of each private contract that he or she has entered into for the duration of the opt-out period for which the contracts are applicable or fails to permit HCFA to inspect them upon request.

(b) If a physician or practitioner fails to maintain opt-out in accordance with paragraph (a) of this section, the following results obtain:

(1) All of the private contracts between the physician or practitioner and Medicare beneficiaries are deemed null and void.

(2) The physician's or practitioner's opt-out of Medicare is nullified.

(3) The physician or practitioner must submit claims to Medicare for all Medicare-covered items and services furnished to Medicare beneficiaries.

(4) The physician or practitioner will not receive Medicare payment on Medicare claims for the remainder of the opt-out period.

(5) The physician is subject to the limiting charge provisions of § 414.48 of this chapter.

(6) The practitioner may not reassign any claim except as provided in § 424.80 of this chapter.

(7) The practitioner may neither bill nor collect an amount from the beneficiary except for applicable deductible and coinsurance amounts.

(8) The physician or practitioner may not attempt to once more meet the criteria for properly opting-out until the now-nullified 2-year opt-out period expires.

§ 405.440 Emergency and urgent care services.

(a) A physician or practitioner who has opted-out of Medicare under this subpart need not enter into a private contract to furnish emergency care services or urgent care services to a Medicare beneficiary. Accordingly, a physician or practitioner will not be determined to have failed to maintain opt-out if he or she furnishes emergency care services or urgent care services to a Medicare beneficiary with whom the physician or practitioner has not previously entered into a private contract, provided the physician or practitioner complies with the billing requirements specified in paragraph (b) of this section.

(b) When a physician or practitioner furnishes emergency care services or urgent care services to a Medicare beneficiary with whom the physician or practitioner has not previously entered into a private contract, he or she:

(1) Must submit a claim to Medicare in accordance with both 42 CFR part 424 and Medicare instructions (including but not limited to complying with proper coding of emergency or urgent care services furnished by physicians and practitioners who have opted-out of Medicare).

(2) May collect no more than—

(i) The Medicare limiting charge, in the case of a physician; or

(ii) The deductible and coinsurance, in the case of a practitioner.

(c) Emergency care services or urgent care services furnished to a Medicare beneficiary with whom the physician or practitioner has previously entered into a private contract (that is, entered into before the onset of the emergency medical condition or urgent medical condition), are furnished under the terms of the private contract.

(d) Medicare may make payment for emergency care services or urgent care services furnished by a physician or practitioner who has properly opted-out when the services are furnished and the claim for services is made in accordance with this section.

§ 405.445 Renewal and early termination of opt-out.

(a) A physician or practitioner may renew opt-out by filing an affidavit with each carrier to which an affidavit was submitted for the first opt-out period, (as specified in § 405.420), and to each carrier to which a claim was submitted under § 405.440 during the previous opt-out period, provided the affidavits are filed within 30 days after the current opt-out period expires.

(b) To properly terminate opt-out a physician or practitioner must:

(1) Not have previously opted out of Medicare.

(2) Notify all Medicare carriers with which he or she filed an affidavit of the termination of the opt-out no later than 90 days after the effective date of the opt-out period.

(3) Refund to each beneficiary with whom he or she has privately contracted all payment collected in excess of:

(i) In the case of physicians: the Medicare limiting charge; or

(ii) In the case of practitioners: the deductible and coinsurance.

(4) Notify all beneficiaries with whom the physician or practitioner entered into private contracts of the physician's or practitioner's decision to terminate opt-out and of the beneficiaries' right to have claims filed on their behalf with Medicare for the services furnished during the period between the effective date of the opt-out and the effective date of the termination of the opt-out period.

(c) When the physician or practitioner properly terminates opt-out in accordance with paragraph (b), he or she will be reinstated in Medicare as if there had been no opt-out, and the provision of § 405.425 shall not apply unless the physician or practitioner subsequently properly opts out.

§ 405.450 Appeals.

(a) A determination by HCFA that a physician or practitioner has failed to properly opt-out, failed to maintain opt-out, failed to timely renew opt-out, failed to privately contract, or failed to properly terminate opt-out is an initial determination for purposes of § 405.803.

(b) A determination by HCFA that no payment can be made to a beneficiary for the services of a physician who has opted-out is an initial determination for purposes of § 405.803.

§ 405.455 Medicare+Choice.

An organization that has a contract with HCFA to provide one or more Medicare+Choice (M+C) plans to beneficiaries (part 422 of this chapter):

(a) Must acquire and maintain information from Medicare carriers on physicians and practitioners who have opted-out of Medicare.

(b) Must make no payment directly or indirectly for Medicare covered services furnished to a Medicare beneficiary by a physician or practitioner who has opted-out of Medicare.

(c) May make payment to a physician or practitioner who furnishes emergency or urgent care services to a beneficiary who has not previously entered into a private contract with the physician or practitioner.

Subpart E—Criteria for Determining Reasonable Charges

2. The authority citation for part 405, subpart E, continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

3. Section 405.517 is revised to read as follows:

§ 405.517 Payment for drugs and biologicals that are not paid on a cost or prospective payment basis.

(a) *Applicability.* Payment for a drug or biological that is not paid on a cost or prospective payment basis is determined by the standard methodology described in paragraph (b) of this section. Examples of when this procedure applies include a drug or biological furnished incident to a physician service, a drug or biological furnished by an independent dialysis facility that is not included in the ESRD composite rate set forth in § 413.170(c) of this chapter, and a drug or biological furnished as part of the durable medical equipment benefit.

(b) *Methodology.* Payment for a drug or biological described in paragraph (a) of this section is based on the lower of the actual charge on the Medicare claim for benefits or 95 percent of the national average wholesale price of the drug or biological.

(c) *Multiple-source drugs.* For multiple-source drugs and biologicals, for purposes of this regulation, the average wholesale price is defined as the lesser of the median average wholesale price for all sources of the generic forms of the drug or biological or the lowest average wholesale price of the brand name forms of the drug or biological.

4. A new § 405.520 is added to read as follows:

§ 405.520 Payment for physician assistant, nurse practitioner, and clinical nurse specialist services and services furnished incident to their professional services.

(a) *General rule.* Physician assistant, nurse practitioner, and clinical nurse specialist services, and services and supplies furnished incident to their professional services, are paid in accordance with the physician fee schedule. The payment for physician assistant services may not exceed the limits at § 414.52 of this chapter. The payment for nurse practitioner and clinical nurse specialist services may not exceed the limits at § 414.56 of this chapter.

(b) *Requirements.* Medicare payment is made only if all claims for payment are made on an assignment-related basis in accordance with § 424.55 of this chapter, that sets forth, respectively, the conditions for coverage of physician assistant services, nurse practitioner services and clinical nurse specialist services, and services and supplies furnished incident to their professional services.

(c) *Civil money penalties.* Any person or entity who knowingly and willingly bills a Medicare beneficiary amounts in excess of the appropriate coinsurance and deductible is subject to a civil money penalty not to exceed $2,000 for each bill or request for payment.

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

B. Part 410 is amended as set forth below:

1. The authority citation for part 410 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§ 410.32 [Amended]

2. In § 410.32(a)(3), the last word, ''section,'' is removed and the word ''paragraph'' is added in its place.

3. A new section 410.59 is added to read as follows:

§ 410.59 Outpatient occupational therapy services: Conditions.

(a) *Basic rule.* Medicare Part B pays for outpatient occupational therapy services if they meet the following conditions:

(1) They are furnished to a beneficiary while he or she is under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine.

(2) They are furnished under a written plan of treatment that meets the requirements of § 410.61.

(3) They are furnished—

(i) By a provider as defined in § 489.2 of this chapter, or by others under arrangements with, and under the supervision of, a provider; or

(ii) By or under the personal supervision of an occupational therapist in private practice as described in paragraph (c) of this section.

(b) *Outpatient occupational therapy services to certain inpatients of a*

hospital or a CAH or SNF. Medicare Part B pays for outpatient occupational therapy services to an inpatient of a hospital, CAH, or SNF who requires them but who has exhausted or is otherwise ineligible for benefit days under Medicare Part A.

(c) *Special provisions for services furnished by occupational therapists in private practice.* (1) *Basic Qualifications.* In order to qualify under Medicare as a supplier of outpatient occupational therapy services, each individual occupational therapist in private practice must meet the following requirements:

(i) Is legally authorized (if applicable, licensed, certified, or registered) to engage in the private practice of occupational therapy by the State in which he or she practices, and practices only within the scope of his or her license, certification, or registration.

(ii) Engages in the private practice of occupational therapy on a regular basis, in one of the following practice types:

(A) An individual operating an unincorporated solo practice.

(B) An individual practicing as a member of a partnership or unincorporated group practice.

(C) An individual practicing as an employee of an unincorporated solo practice, partnership, or group practice, or an employee of a professional corporation or other incorporated occupational therapy practice. Private practice does not include any individual during the time he or she is working as an employee of a provider.

(iii) Bills Medicare only for services furnished in his or her private practice office space, or in the patient's home. A therapist's private practice office space refers to the location(s) where the practice is operated, in the State(s) where the therapist (and practice, if applicable) is legally authorized to furnish services, during the hours that the therapist engages in practice at that location. When services are furnished in private practice office space, that space must be owned, leased, or rented by the practice and used for the exclusive purpose of operating the practice. A patient's home does not include any institution that is a hospital, an CAH, or a SNF.

(iv) Treats individuals who are patients of the practice and for whom the practice collects fees for the services furnished.

(2) Supervision of occupational therapy services. Occupational therapy services are performed by, or under the personal supervision of, the occupational therapist in private practice. All services not performed personally by the therapist must be performed by employees of the practice, personally supervised by the therapist, and included in the fee for the therapist's services.

(d) *Excluded expenses.* No service is included as an outpatient occupational therapy service if it would not be included as an inpatient hospital service if furnished to a hospital or CAH inpatient.

(e) *Annual limitation on incurred expenses.* (1) *Amount of limitation.* (i) In 1999, no more than $1500 of allowable charges incurred in a calendar year for outpatient occupational therapy services are recognized incurred expenses.

(ii) In 2002 and thereafter, the limitation shall be determined by increasing the limitation in effect in the previous calendar year by the increase in the Medicare Economic Index for the current year.

(2) For purposes of applying the limitation, outpatient physical therapy includes:

(i) Except as provided in paragraph (e)(3) of this section, outpatient occupational therapy services furnished under this section;

(ii) Outpatient occupational therapy services furnished by a comprehensive outpatient rehabilitation facility;

(iii) Outpatient occupational therapy services furnished by a physician or incident to a physician's service;

(iv) Outpatient occupational therapy services furnished by a nurse practitioner, certified nurse specialist, or physician assistant or incident to their services.

(3) For purposes of applying the limitation, outpatient occupational therapy services excludes services furnished by a hospital or CAH directly or under arrangements.

4. Section 410.60 is revised to read as follows:

§ 410.60 Outpatient physical therapy services: Conditions.

(a) *Basic rule.* Medicare Part B pays for outpatient physical therapy services if they meet the following conditions:

(1) They are furnished to a beneficiary while he or she is under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine.

(2) They are furnished under a written plan of treatment that meets the requirements of § 410.61.

(3) They are furnished—

(i) By a provider as defined in § 489.2 of this chapter, or by others under arrangements with, and under the supervision of, a provider; or

(ii) By or under the personal supervision of a physical therapist in private practice as described in paragraph (c) of this section.

(b) *Outpatient physical therapy services to certain inpatients of a hospital or a CAH or SNF.* Medicare Part B pays for outpatient occupational therapy services to an inpatient of a hospital, CAH, or SNF who requires them but who has exhausted or is otherwise ineligible for benefit days under Medicare Part A.

(c) *Special provisions for services furnished by physical therapists in private practice. (1) Basic Qualifications.*

In order to qualify under Medicare as a supplier of outpatient physical therapy services, each individual physical therapist in private practice must meet the following requirements:

(i) Is legally authorized (if applicable, licensed, certified, or registered) to engage in the private practice of physical therapy by the State in which he or she practices, and practices only within the scope of his or her license, certification, or registration.

(ii) Engages in the private practice of physical therapy on a regular basis, in one of the following practice types:

(A) An individual operating an unincorporated solo practice.

(B) An individual practicing as a member of an unincorporated partnership or unincorporated group practice.

(C) An individual practicing as an employee of an unincorporated solo practice, partnership, or group practice, or an employee of a professional corporation or other incorporated physical therapy practice. Private practice does not include any individual during the time he or she is working as an employee of a provider.

(iii) Bills Medicare only for services furnished in his or her private practice office space, or in the patient's home. A therapist's private practice office space refers to the location(s) where the practice is operated, in the State(s) where the therapist (and practice, if applicable) is legally authorized to furnish services, during the hours that the therapist engages in practice at that location. When services are furnished in private practice office space, that space must be owned, leased, or rented by the practice and used for the exclusive purpose of operating the practice. A patient's home does not include any institution that is a hospital, a CAH, or a SNF.

(iv) Treats individuals who are patients of the practice and for whom the practice collects fees for the services furnished.

(2) *Supervision of physical therapy services.* Physical therapy services are performed by, or under the personal supervision of, the physical therapist in

private practice. All services not performed personally by the therapist must be performed by employees of the practice, personally supervised by the therapist, and included in the fee for the therapist's services.

(d) *Excluded expenses.* No service is included as an outpatient physical therapy service if it would not be included as an inpatient hospital service if furnished to a hospital or CAH inpatient.

(e) *Annual limitation on incurred expenses.* (1) Amount of limitation. In 1999, no more than $1500 of allowable charges incurred in a calendar year for outpatient physical therapy services are recognized incurred expenses.

(ii) In 2002 and thereafter, the limitation shall be determined by increasing the limitation in effect in the previous calendar year by the increase in the Medicare Economic Index for the current year.

(2) For purposes of applying the limitation, outpatient occupational therapy includes:

(i) Except as provided in paragraph (e)(3) of this section, outpatient physical therapy services furnished under this section;

(ii) Except as provided in paragraph (e)(3) of this section, outpatient speech-language pathology services furnished under § 410.62;

(iii) Outpatient physical therapy and speech-language pathology services furnished by a comprehensive outpatient rehabilitation facility;

(iv) Outpatient physical therapy and speech-language pathology services furnished by a physician or incident to a physician's service;

(v) Outpatient physical therapy and speech-language pathology services furnished by a nurse practitioner, certified nurse specialist, or physician assistant or incident to their services.

(3) For purposes of applying the limitation, outpatient physical therapy excludes services furnished by a hospital or CAH directly or under arrangements.

5. In § 410.61 pargraphs (a) through (d) and (e)(1) are revised to read as follows:

§ 410.61 Plan of treatment requirements for outpatient rehabilitation services.

(a) *Basic requirement.* Outpatient rehabilitation services (including services furnished by a qualified physical or occupational therapist in private practice), must be furnished under a written plan of treatment that meets the requirements of paragraphs (b) through (e) of this section.

(b) *Establishment of the plan.* The plan is established before treatment is begun by one of the following:

(1) A physician.

(2) A physical therapist who will furnish the physical therapy services.

(3) A speech-language pathologist who will furnish the speech-language pathology services.

(4) An occupational therapist who will furnish the occupational therapy services.

(c) *Content of the plan.* The plan prescribes the type, amount, frequency, and duration of the physical therapy, occupational therapy, or speech-language pathology services to be furnished to the individual, and indicates the diagnosis and anticipated goals.

(d) *Changes in the plan.* Any changes in the plan—

(1) Are made in writing and signed by one of the following:

(i) The physician.

(ii) The physical therapist who furnished the physical therapy services.

(iii) The occupational therapist who furnishes the physical therapy services.

(iv) The speech-language pathologist who furnishes the speech-language pathology services.

(v) A registered professional nurse or a staff physician, in accordance with oral orders from the physician, physical therapist, occupational therapist, or speech-language pathologist who furnishes the services.

(2) The changes are incorporated in the plan immediately.

(e) *Review of the plan.* (1) The physician reviews the plan as often as the individual's condition requires, but at least within the first 62 days and at least every 31 days after each previous review.

* * * * *

6. In § 410.62, the section heading is revised, paragraph (a)(3) is amended to add ''as defined in § 489.2'' after the words, ''by a provider'', and a new paragraph (d) is added to read as follows:

§ 410.62 Outpatient speech-language pathology services: Conditions and exclusions.

* * * * *

(d) *Limitation.* After 1998, outpatient speech pathology services are subject to the limitation in 410.60(e).

* * * * *

7. New §§ 410.74, 410.75, 410.76, and 410.77 are added to subpart B to read as follows:

Subpart B—Medical and Other Health Services

* * * * *

§ 410.74 Physician assistant services.

(a) *Basic rule.* Medicare Part B covers physician assistant services only if the following conditions are met:

(1) The services would be covered as physician services if furnished by a physician (as used in this section, the term ''physician'' means a doctor of medicine or osteopathy, as set forth in section 1861(r)(1) of the Act).

(2) The physician assistant—

(i) Meets the qualification requirements set forth in paragraph (c) of this section;

(ii) Is legally authorized to perform the services in the State which they are performed;

(iii) Performs services that are not otherwise precluded from coverage because of a statutory exclusion;

(iv) Performs the services under the general supervision of a physician (that is, the supervising physician need not be physically present when the physician assistant is performing the services unless required by State law; however, the supervising physician must be immediately available to the physician assistant for consultation); and

(v) Furnishes services that are billed by the employer of a physician assistant; and

(vi) Performs the services—

(A) In all settings in either rural and urban areas; or

(B) As an assistant at surgery.

(b) *Services and supplies furnished incident to physician assistant services.* Medicare covers services and supplies (including drugs and biologicals that cannot be self-administered) that are furnished incident to the physician assistant services described in paragraph (a) of this section. These services and supplies are covered only if they—

(1) Would be covered if furnished by a physician or as incident to the professional services of a physician;

(2) Are the type that are commonly furnished in a physician office and are either furnished without charge or are included in the bill for the physician assistant services;

(3) Are, although incidental, an integral part of the professional service performed by the physician;

(4) Are performed under the direct supervision of the physician assistant (that is, the physician assistant is physically present and immediately available); and

(5) Are performed by the employee of a physician assistant or an entity that employs both the physician assistant or ancillary personnel.

(c) *Qualifications.* For Medicare Part B coverage of his or her services, a

physician assistant must meet the applicable State requirements governing the qualifications for physician assistants and at least one of the following conditions:

(1) Be certified by either the National Commission on Certification of Physician Assistants to assist primary care physicians or the National Board for Certification of Orthopedic Physician assistants to assist orthopedic surgeons; or

(2) Have satisfactorily completed a program for preparing physician assistants that was at least 1 academic year in length, consisted of supervised clinical practice and at least 4 months (in aggregate) of classroom instruction directed toward preparing students to deliver health care, and was accredited by either the Commission on Accreditation of Allied Health Education Programs or the American Society of Orthopedic Physician Assistants; or

(3) Have satisfactorily completed a formal education program for preparing physician assistants that does not meet the requirements of § 410.74(c)(2) and have assisted physicians for a total of 12 months during the 18-month period that ended on [Insert 18 months from the effective date of final rule].

(d) *Professional services.* Physician assistants can be paid for professional services only if the services have been professionally performed by them and no facility or other provider charges for the service or is paid any amount for the furnishing of those professional services.

(1) Supervision of other nonphysician staff by physician does not constitute personal performance of a professional service by physician assistants.

(2) If a service is not payable by HCFA under this provision, the beneficiary is not liable for payment for the service. Physician assistants may not charge a beneficiary for a service not payable under this provision. If a beneficiary has made payment for the services, physician assistants must make the appropriate refund to the beneficiary.

(3) Examples of the types of professional services that physician assistants may furnish include services such as physical examinations, minor surgery, setting casts for simple fractures, interpreting x-rays, and other activities that involve an independent evaluation or treatment of the patient's condition. These are services that have been traditionally reserved for physicians and can be furnished by physician assistants only if State law or regulation governing the physician assistant scope of practice authorizes them to perform such services in the State in which they are practicing.

§ 410.75 Nurse practitioner services.

(a) *Definition.* As used in this section, the term ''physician'' means a doctor of medicine or osteopathy, as set forth in section 1861(r)(1) of the Act.

(b) *Qualifications.* For Medicare Part B coverage of his or her services, a nurse practitioner must—

(1) Be a registered nurse who is currently licensed to practice in the State where he or she practices, be authorized to perform the services of a nurse practitioner in accordance with State law, and have a master's degree in nursing;

(2) Be certified as a nurse practitioner by a professional association recognized by HCFA that has, at a minimum, eligibility requirements that meet the standards in paragraph (b)(1) of this section; or

(3) Meet the requirements for a nurse practitioner set forth in paragraph (b)(1) of this section, except for the master's degree requirement, and have received before [Insert 3 years from effective date of final rule] a certificate of completion from a formal advanced practice program that prepares registered nurses to perform an expanded role in the delivery of primary care.

(c) *Services.* Medicare Part B covers nurse practitioner services in all settings in both rural and urban areas, only if the services would be covered if furnished by a physician and the nurse practitioner—

(1) Is legally authorized to perform them in the State in which they are performed;

(2) Performs them while working in collaboration with a physician;

(i) Collaboration is a process in which a nurse practitioner works with a physician to deliver health care services within the scope of the practitioner's expertise, with medical direction and appropriate supervision as provided for in guidelines jointly developed by the practitioner and the physician, or as provided for by other mechanisms defined by Federal regulations, or by the law of the State in which the services are performed.

(ii) The absence of State law or guidelines does not negate the requirement for collaboration.

(iii) The collaborating physician does not need to be present with the nurse practitioner when the service is furnished or to make an independent evaluation of each patient seen by the nurse practitioner.

(iv) Collaboration involves systematic formal planning, assessment, and a practice arrangement that reflects and demonstrates evidence of consultation, recognition of statutory limits, clinical authority and accountability for patient care, according to a mutual agreement that allows the physician and the nurse practitioner to function independently as appropriate; and

(3) Is not performing services otherwise precluded from coverage because of one of the statutory exclusions.

(d) *Services and supplies incident to nurse practitioner services.* Medicare Part B covers services and supplies (including drugs and biologicals that cannot be self-administered) incident to nurse practitioner services that meet the requirements in paragraph (c) of this section. These services and supplies are covered only if they—

(1) Would be covered if furnished by a physician or as incident to the professional services of a physician;

(2) Are of the type that are commonly furnished in a physician office and are either furnished without charge or are included in the bill for the nurse practitioner services;

(3) Although incidental, are an integral part of the professional service performed by the nurse practitioner; and

(4) Are performed under the direct supervision of the nurse practitioner (that is, the nurse practitioner must be physically present and immediately available).

(e) *Professional services.* Nurse practitioners can be paid for professional services only when the services have been personally performed by them and no facility or other provider charges or is paid any amount for the furnishing of such professional services.

(1) Supervision of other nonphysician staff by nurse practitioners does not constitute personal performance of a professional service by nurse practitioners.

(2) If a service is not payable by HCFA under this provision, the beneficiary is not liable for payment for the service. Nurse practitioners may not charge a beneficiary for a service not payable under this provision. If a beneficiary has made payment for the services, the nurse practitioner must make the appropriate refund to the beneficiary.

(3) Examples of the types of professional services that nurse practitioners may provide include services such as physical examinations, minor surgery, setting casts for simple fractures, interpreting x-rays, and other activities that involve an independent evaluation or treatment of the patient's condition. These are services that have been traditionally reserved for physicians and can only be furnished by

nurse practitioners if State law or regulation governing the nurse practitioner scope of practice authorizes them to perform such services in the State in which they are practicing.

§ 410.76 Clinical nurse specialist services.

(a) *Definition.* As used in this section, the term ''physician'' means a doctor of medicine or osteopathy, as set forth in section 1861(r)(1) of the Act.

(b) *Qualifications.* For Medicare Part B coverage of his or her services, a clinical nurse specialist must—

(1) Be a registered nurse who is currently licensed to practice in the State where he or she practices, be authorized to perform the services of a clinical nurse specialist in accordance with State law, and have a master's degree in a defined clinical area of nursing from an accredited educational institution;

(2) Be certified as a clinical nurse specialist by a professional association recognized by HCFA that has, at a minimum, eligibility requirements that meet the standards in paragraph (b)(1) of this section; or

(3) Meet the requirements for a clinical nurse specialist set forth in paragraph (b)(1) of this section, except for the master's degree requirement, and have received before [Insert 3 years from effective date of final rule] a certificate of completion from a formal advanced practice program that prepares registered nurses to perform an expanded role in the delivery of primary care.

(c) *Services.* Medicare Part B covers clinical nurse specialist services in all settings in both rural and urban areas only if the services would be covered if furnished by a physician and the clinical nurse specialist—

(1) Is legally authorized to perform them in the State in which they are performed; and

(2) Performs them while working in collaboration with a physician.

(i) Collaboration is a process in which a clinical nurse specialist works with a physician to deliver health care services within the scope of the clinical nurse specialist's expertise, with medical direction and appropriate supervision as provided for in guidelines jointly developed by the clinical nurse specialist and the physician, or as provided for by other mechanisms defined by Federal regulations, or by the law of the State in which the services are performed.

(ii) The absence of State law or guidelines does not negate the requirement for collaboration.

(iii) The collaborating physician does not need to be present with the clinical nurse specialist when the service is furnished or to make an independent evaluation of each patient seen by the clinical nurse specialist.

(iv) Collaboration involves systematic formal planning, assessment, and a practice arrangement that reflects and demonstrates evidence of consultation, recognition of statutory limits, clinical authority and accountability for patient care, according to a mutual agreement that allows the physician and the clinical nurse specialist to function independently as appropriate; and

(3) Is not performing services that are otherwise precluded from coverage by one of the statutory exclusions.

(d) *Services and supplies incident to clinical nurse specialist services.* Medicare Part B covers services and supplies (including drugs and biologicals that cannot be self-administered) incident to a clinical nurse specialist's services that meet the requirements in paragraph (c) of this section. These services and supplies are covered only if they—

(1) Would be covered if furnished by a physician or as incident to the professional services of a physician;

(2) Are of the type that are commonly furnished in a physician office and are either furnished without charge or are included in the bill for the clinical nurse specialist services;

(3) Although incidental, are an integral part of the professional service performed by the clinical nurse specialist; and

(4) Are performed under the direct supervision of the clinical nurse specialist (that is, the clinical nurse specialist must be physically present and immediately available).

(e) *Professional services.* Clinical nurse specialists can be paid for professional services only when the services have been personally performed by them and no facility or other provider charges or is paid any amount for the furnishing of such professional services.

(1) Supervision of other nonphysician staff by clinical nurse specialists does not constitute personal performance of a professional service by clinical nurse specialists.

(2) If a service is not payable by HCFA under this provision, the beneficiary is not liable for payment for the service. Clinical nurse specialists may not charge a beneficiary for a service not payable under this provision. If a beneficiary has made payment for the services, the clinical nurse specialist must make the appropriate refund to the beneficiary.

(3) Examples of the types of professional services that clinical nurse specialists may provide include services such as physical examinations, minor surgery, setting casts for simple fractures, interpreting x-rays, and other activities that involve an independent evaluation or treatment of the patient's condition. These are services that have been traditionally reserved for physicians and can only be furnished by clinical nurse specialists if State law or regulation governing the clinical nurse specialist scope of practice authorizes them to perform such services in the State in which they are practicing.

§ 410.77 Certified nurse-midwife services: Qualifications and conditions.

(a) *Qualifications.* For Medicare coverage of his or her services, a certified nurse-midwife must—

(1) Be currently licensed to practice in the State as a registered professional nurse;

(2) Be legally authorized under State law or regulations to practice as a nurse-midwife in the State in which the services are performed;

(3) Have successfully completed a program of study and clinical experience for nurse-midwives, as specified by the State, or, if the State does not specify a program of study and clinical experience that nurse-midwives must complete to practice in that State, meet one of the following criteria:

(i) Be currently certified as a nurse-midwife by the American College of Nurse-Midwives, in accordance with its October 1994 requirements or subsequent amendments to those requirements recognized by the Secretary, or by another certifying entity recognized by the Secretary.

(ii) Have successfully completed a formal educational program (of at least 1 academic year) that, upon completion, qualifies him or her to take the certification examination offered by the American College of Nurse-Midwives or by another certifying entity recognized by the Secretary. (The individual is not required to take the examination, however.)

(iii) Have successfully completed a formal educational program for preparing registered nurses to furnish gynecological and obstetrical care during pregnancy, delivery, and the postpartum period and care to normal newborns, and practiced as a nurse-midwife for a total of 12 months during any 18-month period from August 8, 1976 to July 16, 1982.

(b) *Services.* Certified nurse-midwife services are services furnished by a certified nurse-midwife and services and supplies furnished as an incident to the certified nurse-midwife services that—

(1) Are within the scope of practice authorized by the law of the State in which they are furnished and would otherwise be covered if furnished by a physician or as an incident to a physician service; and

(2) Unless required by State law, are provided without regard to whether the certified nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

(c) *Incident to services: Basic rule.* Medicare covers services and supplies furnished incident to the services of a certified nurse-midwife, including drugs and biologicals that cannot be self-administered, if the services and supplies meet the following conditions:

(1) They would be covered if furnished by a physician or as incident to the professional services of a physician.

(2) They are of the type that are commonly furnished in a physician office and are either furnished without charge or are included in the bill for the certified nurse-midwife services.

(3) Although incidental, they are an integral part of the professional service performed by the certified nurse-midwife.

(4) They are furnished under the direct supervision of a certified nurse-midwife (that is, the midwife is physically present and immediately available).

(d) *Professional services.* A nurse-midwife can be paid for a professional service only when the service has been personally performed by the nurse-midwife.

(1) Supervision of other nonphysician staff by a nurse-midwife does not constitute personal performance of a professional service by the nurse-midwife.

(2) If a service is not payable by HCFA under this provision, the beneficiary is not liable for payment for the service. A nurse-midwife may not charge a beneficiary for a service not payable under this provision. If the beneficiary has made payment for the service, the nurse-midwife must make the appropriate refund to the beneficiary.

(3) A nurse-midwife may provide services related to the maternity cycle that includes pregnancy, labor, and the immediate post partum period and other services including obstetrical and gynecological services.

(4) The services that the nurse-midwife performs are not services otherwise precluded from coverage because of one of the statutory exclusions.

7. In § 410.150, the introductory text to paragraph (b) is republished, and new paragraphs (b)(15) and (b)(16) are added to read as follows:

§ 410.150 To whom payment is made.

* * * * *

(b) *Specific rules.* Subject to the conditions set forth in paragraph (a) of this section, Medicare Part B pays as follows:

* * * * *

(15) To the qualified employer of a physician assistant for professional services furnished by the physician assistant and for services and supplies furnished incident to their services. Payment is made to the employer of a physician assistant regardless of whether the physician assistant is employed as a W–2 employee or whether the physician assistant is a 1099 employee who is acting as an independent contractor. A qualified employer is not a group of physician assistants that incorporate to bill for their services. Payment is made only if no facility or other provider charges or is paid any amount for services furnished by a physician assistant.

(16) To a nurse practitioner or clinical nurse specialist for professional services furnished by a nurse practitioner or clinical nurse specialist in all settings in both rural and nonrural areas and for services and supplies furnished incident to those services. Payment is made only if no facility or other provider charges or is paid any amount for the furnishing of the professional services of the nurse practitioner or clinical nurse specialist.

8. In § 410.152, the headings to paragraphs (a) and (a)(1) are republished, and paragraph (a)(1)(v) is revised to read as follows:

§ 410.152 Amount of payment.

(a) *General provisions*—(1) *Exclusion from incurred expenses.* * * *

(v) In the case of expenses incurred for outpatient physical therapy services including speech-language pathology services, the expenses excluded are from the incurred expenses under § 410.60(e). In the case of expenses incurred for outpatient occupational therapy including speech-language pathology services, the expenses excluded are from the incurred expenses under § 410.59(e).

* * * * *

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

c. Part 413 is amended as set forth below.

1. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1861(v)(1)(A), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x(v)(1)(A), and 1395hh).

2. Section 413.125 is revised to read as follows:

§ 413.125 Payment for home health agency services.

The reasonable cost of outpatient rehabilitation services furnished by a home health agency to homebound patients who are not entitled to home health benefits may not exceed the amounts payable under part 414 of this chapter for comparable services.

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

C. Part 414 is amended as set forth below:

1. The authority citation for part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(1) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(1)).

2. In § 414.1, the introductory text is republished, and the following statutory authority is added in numerical order to read as follows:

§ 414.1 Basis and scope.

This part implements the indicated provisions of the following sections of the Act:

1802—Rules for private contracts by Medicare beneficiaries.

* * * * *

3. Sections 414.20 through 414.62 are redesignated as subpart B, and a new heading is added to read ''Physicians and Other Practitioners''.

4. In § 414.22, the introductory text to the section and the heading to paragraph (b) are republished, and new paragraph (b)(5) is added to read as follows:

§ 414.22 Relative value units (RVUs).

HCFA establishes RVUs for physician work, physician practice expense, and malpractice insurance.

* * * * *

(b) *Practice expense RVUs.* * * *

(5) For services furnished in 1999, the practice expense RVUs are based on 75 percent of the practice expense RVUs applicable to services furnished in 1998 and 25 percent of the relative practice expense resources involved in furnishing the service. For services furnished in 2000, the practice expense RVUs are based on 50 percent of the practice expense RVUs applicable to services furnished in 1998 and 50 percent of the relative practice expense resources involved in furnishing the service. For services furnished in 2001, the practice expense RVUs are based on 25 percent of the practice expense RVUs applicable to services furnished in 1998 and 75 percent of the relative practice expense resources involved in furnishing the service. For services furnished in 2002 and subsequent years, the practice expense RVUs are based entirely on relative practice expense resources.

(i) Usually one of two levels of practice expense RVUs per code can be applied to each service. The lower practice expense RVUs apply to services furnished to hospital or ambulatory surgical center patients. The higher practice expense RVUs apply to services performed in a physician office; services, other than evaluation and management services, furnished to patients in a nursing facility, in a facility or institution other than a hospital or ambulatory surgical center, or in the home; and other services furnished to facility patients for which the facility payment does not include physician practice costs.

(ii) Only one practice expense RVU per code can be applied for each of the following services: services that have only technical component practice expense RVUs or only professional component practice expense RVUs; evaluation and management services, such as hospital or nursing facility visits, that are furnished exclusively in one setting; and major surgical services.

* * * * *

6. In § 414.32, paragraph (b) is revised to read as follows:

§ 414.32 Determining payments for certain physician services furnished in facility settings.

* * * * *

(b) *General rule.* If physician services of the type routinely furnished in physician offices are furnished in facility settings before January 1, 1999, the physician fee schedule amount for those services is determined by reducing the practice expense RVUs for the services by 50 percent. For services furnished on or after January 1, 1999, the practice expense RVUs are determined in accordance with § 414.22(b)(5).

* * * * *

7. In § 414.34, the section heading is revised, and a new paragraph (a)(2)(iii) is added to read as follows:

§ 414.34 Payment for services and supplies incident to a physician service.

* * * * *

(a) *Medical supplies.* * * *

(2) * * *

(iii) It is furnished before January 1, 1999.

* * * * *

8. In § 414.52, the section heading and the introductory text are revised, and a new paragraph (d) is added to read as follows:

§ 414.52 Payment for physician assistant services.

Allowed amounts for the services of a physician assistant furnished beginning January 1, 1992 and ending December 31, 1997, may not exceed the limits specified in paragraphs (a) through (c) of this section. Allowed amounts for the services of a physician assistant furnished beginning January 1, 1998, may not exceed the limits specified in paragraph (d) of this section.

* * * * *

(d) For services (other than assistant-at-surgery services) furnished beginning January 1, 1998, 85 percent of the physician fee schedule amount for the service. For assistant-at-surgery services, 85 percent of the physician fee schedule amount that would be allowed under the physician fee schedule if the assistant-at-surgery services were furnished by a physician.

9. Section 414.56 is revised to read as follows:

§ 414.56 Payment for nurse practitioner and clinical nurse specialist services.

(a) *Rural areas.* For services furnished beginning January 1, 1992 and ending December 31, 1997, allowed amounts for the services of a nurse practitioner or a clinical nurse specialist in a rural area (as described in section 1861(s)(2)(K)(iii) of the Act) may not exceed the following limits.

(1) for services furnished in a hospital (including assistant-at-surgery services), 75 percent of the physician fee schedule amount for the service.

(2) For all other services, 85 percent of the physician fee schedule amount for the service.

(b) *Non-rural areas.* For services furnished beginning January 1, 1992 and ending December 31, 1997, allowed amounts for the services of a nurse practitioner or a clinical nurse specialist in a nursing facility may not exceed 85 percent of the physician fee schedule amount for the service.

(c) *Beginning January 1, 1998.* For services (other than assistant at surgery services) furnished beginning January 1, 1998, allowed amounts for the services of a nurse practitioner or clinical nurse specialist may not exceed 85 percent of the physician fee schedule amount for the service. For assistant at surgery services, allowed amounts for the services of a nurse practitioner or clinical nurse specialist may not exceed 85 percent of the physician fee schedule amount that would be allowed under the physician fee schedule if the assistant at surgery service were furnished by a physician.

PART 415—SERVICES FURNISHED BY PHYSICIANS IN PROVIDERS, SUPERVISING PHYSICIANS IN TEACHING SETTINGS, AND RESIDENTS IN CERTAIN SETTINGS

D. Part 415 is amended as set forth below:

1. The authority citation for part 415 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (41 U.S.C. 1302 and 1395hh).

2. In § 415.110, the section heading is revised, paragraph (a) is revised, paragraph (b) is redesignated as paragraph (c), and a new paragraph (b) is added to read as follows:

§ 415.110 Conditions for payment: Medically directed anesthesia services.

(a) *General payment rule.* The Medicare carrier pays for the physician's medical direction of anesthesia services for one service or two through four concurrent anesthesia services furnished after December 31, 1998, only if each of the services meets the condition in § 415.102(a) and the following additional conditions:

(1) For each patient, the physician—

(i) Performs a pre-anesthetic examination and evaluation, or reviews one performed by another qualified individual permitted by the State to administer anesthetics;

(ii) Participates in the development of the anesthesia plan and gives final approval of the proposed plan;

(iii) Personally participates in the most demanding aspects of the anesthesia plan;

(iv) Ensures that any aspect of the anesthesia plan not performed by the anesthesiologist is performed by a qualified individual as specified in operating instructions;

(v) Monitors the course of anesthesia at intervals medically indicated by the nature of the procedure and the patient's condition;

(vi) Remains physically present in the facility and immediately available for diagnostic and therapeutic emergencies;

(vii) Provides indicated post-anesthesia care or ensures that it is provided by a qualified individual as described in paragraph (a)(1)(iv) of this section.

(2) The physician directs no more than four anesthesia services concurrently and does not perform any other services while he or she is directing the single or concurrent services so that one or more of the conditions in paragraph (a)(1) of this section are not violated.

(3) If the physician personally performs the anesthesia service, the payment rules in § 414.46(c) of this chapter (Physician personally performs the anesthesia procedure) apply.

(b) *Medical documentation.* The physician inclusively documents in the patient's medical record that the conditions set forth in paragraph (a)(1) of this section have been satisfied, specifically documenting personal participation in the most demanding aspects of the anesthesia plan.

* * * * *

PART 424—CONDITIONS FOR MEDICARE PAYMENT

E. Part 424 is amended as set forth below:

1. The authority citation for part 424 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (41 U.S.C. 1302 and 1395hh).

2. In § 424.24, paragraphs (c)(1)(iii), (c)(3)(ii), and (c)(4) are revised to read as follows:

§ 424.24 Requirements for medical and other health services furnished by providers under Medicare Part B.

* * * * *

(c) *Outpatient physical therapy and speech-language pathology services*—(1) *Content of certification.* * * *

(iii) The services were furnished under a plan of treatment that meets the requirements of § 410.61.

* * * * *

(3) *Signature.* * * *

(ii) If the plan of treatment is established by a physical therapist or speech-language pathologist, the certification must be signed by a physician who has knowledge of the case.

(4) *Recertification*—(i) *Timing.* The first recertification is required by no later than the 62nd day and subsequent recertifications are required at least every 31 days.

(ii) *Content.* The recertification statement must indicate the continuing need for physical therapy or speech-language pathology services and an estimate of how much longer the services will be needed.

(iii) *Signature.* Recertifications must be signed by the physician who reviews the plan of treatment.

* * * * *

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

F. Part 485 is amended as set forth below:

1. The authority citation for part 485 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (41 U.S.C. 1302 and 1395hh).

2. Section 485.705 is revised to read as follows:

§ 485.705 Personnel qualifications.

(a) *General qualification requirements.* Except as specified in paragraphs (b) and (c) of this section, all personnel who are involved in the furnishing of outpatient physical therapy, occupational therapy, and speech-language pathology services directly by or under arrangements with an organization must be legally authorized (licensed or, if applicable, certified or registered) to practice by the State in which he or she performs the functions or actions, and must act only within the scope of his or her state license or State certification or registration.

(b) *Exception for Federally defined qualifications.* The following Federally defined qualifications must be met:

(1) For a physician, the qualifications and conditions as defined in section 1861(r) of the Act and the requirements in part 484 of this chapter.

(2) *For a speech-language pathologist,* the qualifications specified in section 1861(11)(1) of the Act and the requirements in part 484.

(c) *Exceptions when no State Licensing laws or State certification or registration requirements exist.* If no State licensing laws or State certification or registration requirements exist for the profession, the following requirements must be met:

(1) An *administrator* is a person who has a bachelor's degree and:

(i) Has experience or specialized training in the administration of health institutions or agencies; or

(ii) Is qualified and has experience in one of the professional health disciplines.

(2) An *occupational therapist* must meet the requirements in part 484.

(3) An *occupational therapy assistant* must meet the requirements in part 484.

(4) A *physical therapist* must meet the requirements in part 484.

(5) A *physical therapist assistant* must meet the requirements in part 484.

(6) A *social worker* must meet the requirements in part 484.

(7) A *vocational specialist* is a person who has a baccalaureate degree and:

(i) Two years experience in vocational counseling in a rehabilitation setting such as a sheltered workshop, State employment service agency, etc.; or

(ii) At least 18 semester hours in vocational rehabilitation, educational or vocational guidance, psychology, social work, special education or personnel administration, and 1 year of experience in vocational counseling in a rehabilitation setting; or

(iii) A master's degree in vocational counseling.

3. In § 485.711, paragraph (b)(3) is revised to read as follows:

§ 485.711 Conditions of participation: Plan of care and physician involvement.

* * * * *

(b) * * *

(3) The plan of care and results of treatment are reviewed by the physician or by the individual who established the plan at least as often as the patient's condition requires, and the indicated action is taken. (For Medicare patients, the plan must be reviewed by a physician within the first 62 days and at least every 31 days thereafter, in accordance with § 410.61(e) of this chapter.)

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: May 15, 1998.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: May 21, 1998.

Donna E. Shalala,

Secretary.

Note: The following addendums will not appear in the Code of Federal Regulations.

Addendum A—Description of Clinical Practice Expert Panel Data and Methodology

To aid us in collecting the data to implement our methodology for a resource-based system for determining practice expense RVUs for each physician service, we awarded a contract to Abt Associates in March 1995. Under the contract, Abt used Clinical Practice Expert Panels (CPEPs)

to collect data that could be used to generate direct practice expense RVUs for each service. Through the use of CPEPs, Abt furnished us with the direct inputs of physician services. Direct inputs are the quantity and type of nonphysician labor, medical supplies, and medical equipment associated with a service, such as the minutes of a registered nurse's time, a pair of sterile gloves, and a surgical mask. The CPEPs also reported additional items as direct inputs, such as administrative services, including the amount of time medical secretaries and billing and insurance personnel spend in activities related to specific services. Abt priced the direct inputs and determined the direct costs for each service.

The direct inputs do not include the physician's time. Physician time and effort are components of work RVUs and are paid under the work component of the physician fee schedule.

The general approach for establishing a resource-based practice expense system was to use CPEPs to identify as many direct inputs as possible for a physician service furnished to a typical patient (across all age groups) in various settings.

The CPEPs consisted of panels of physicians, practice administrators, and nonphysicians (such as registered nurses, psychologists, and physical therapists). Physician specialty societies and other groups nominated individuals for these positions. Final selections were made by Abt with our assistance.

In all, there were 15 CPEPs. The panels consisted of over 180 members from more than 61 specialties and subspecialties; approximately 50 percent of the panelists were physicians. Each CPEP consisted of 12 to 15 members.

The CPEPs identified the direct inputs involved in each physician service in an office setting and an out-of-office setting (such as a hospital and an ambulatory surgical center). Generally, if a service was furnished both in an office setting and an out-of-office setting but less than 10 percent of the time in either of these settings, it was not profiled in that setting.

We assisted Abt in identifying approximately 6,300 procedure codes for which resource-based practice expense RVUs were to be developed. Approximately 850 of these procedure codes have both technical components (TCs) and professional components (PCs), and we developed practice expense RVUs for both the TC and PC for each of the 850 procedures.

Abt grouped procedure codes included under the physician fee schedule into families of codes clinically related and with relatively comparable direct costs. The classification system for families of procedure codes is a hybrid of the Ambulatory Patient Groups System developed by 3M and the Berenson-Eggers-Holahan (Urban Institute) system. Abt assigned each family of codes to a CPEP based on the physician specialty that predominantly furnished the services. For example, the panels were categorized as integumentary, male genital and urinary, orthopedics, obstetrics and gynecology, ophthalmology, radiology, evaluation and management, general surgery, otolaryngology, miscellaneous internal medicine, gastroenterology, cardiothoracic and vascular, cardiology, anesthesia and pathology, and neurosurgery CPEPs.

Our medical staff, Abt's clinical consultants, and other advisors reviewed this system. Some families of codes were assigned to more than one CPEP to validate resource inputs across CPEPs. For example, the evaluation and management family of codes was assigned to every CPEP except the radiology CPEP and the anesthesia and pathology CPEP.

Abt selected a reference service for each family of codes. (Abt compiled the initial list of reference services based on recommendations from numerous specialty societies.) The following four criteria were established to guide the selection process for the reference service:

- It had to be commonly performed.
- It had to have a mid-range level of resource use relative to other codes in the family.
- It had to be a code whose definition or coding application has not markedly changed in the last several years.
- It had to be performed with minimal variation by all physicians.

In August 1995, physician specialty groups were given an opportunity to review and comment on a draft document containing the procedure code family classification system, the reference code (to serve as a benchmark for creating resource profiles for the remainder of services within each family of procedure codes), and the CPEP to which the family was assigned. The comments were considered by Abt and HCFA in designing the final classification system including the number of CPEPs.

The final classification system contained 229 unique families of codes assigned to 15 CPEP panels. Twelve to 29 families of procedure codes were assigned to each CPEP with most CPEPs reviewing 19 to 23 families of procedure codes.

The CPEPs met twice. During the first CPEP session in February 1996, the CPEPs identified the direct inputs for designated reference services. The CPEPs met again in June 1996 to identify the inputs for the remaining procedure codes covered under the physician fee schedule.

a. Collection of Information From the Clinical Practice Expert Panels

Abt designed the following four uniform worksheets that were used to collect the inputs identified by the CPEPs:

- Worksheet Package G: Services with a global period.
- Worksheet Package P: Services without a global period.
- Worksheet Package M: Evaluation and Management services.
- Worksheet Package Pa: Pathology services.

For labor inputs, either clinical or administrative, the worksheets identified the function or activity with the occupational category of the individual furnishing the service. For clinical functions, examples of occupational categories included a registered nurse, licensed practical nurse, and certified medical assistant. For administrative functions, examples of occupational categories included medical secretaries, insurance or billing clerks, transcriptionists, and scheduling secretaries. The clinical labor worksheets accumulated labor inputs by preservice, service, and postservice periods for surgical procedures with a global period. For surgical procedures without a global period, evaluation and management services, and pathology services, the worksheets accumulated labor inputs by the service period. The administrative labor worksheets collected labor inputs by preservice and postservice periods.

During the first round of the CPEPs, Abt collected detailed data by each of the functions listed within the preservice, service, and postsurgical visit periods of each service. These were activities performed by nonphysician clinical and administrative personnel, not physicians. For example, the evaluation and management services worksheet listed the following clinical activities in the preservice period:

- Obtain medical history/review patient charts.
- Greet patient/provide gowning.
- Perform room preparation/prepare medical equipment.
- Prepare patient.
- Obtain vital signs.
- Other.

Similarly, the following administrative activities were listed in the preservice period:

- Obtain referral from referring M.D.
- Schedule patient/remind patient of appointment.
- Obtain medical records, manage/recall patient database, assemble/develop patient chart.
- Precertify patient/conduct preservice billing.
- Verify insurance/review coverage/register patient.

For the intraservice period, the following clinical activities were listed:

- Obtain medical history.
- Record notes.
- Other.

The following clinical activities were listed in the postservice period:

- Clean room/equipment/shut down equipment.
- Provide postservice education.
- Complete diagnostic medical forms, x-ray requisitions, prescriptions.
- Review results.
- Checkout/provide discharge instructions/complete nursing forms.
- Conduct follow-up phone calls to patient/respond to patient calls/call-in prescription refills.
- Other.

Similarly the following administrative activities were listed in the postservice period:

- Transcribe results/file and manage patient records.
- Schedule postoperative return evaluation and management services/arrange for hospital readmission.
- Notify and complete reports to referring MDs.
- Conduct billing activities (coordinate bill collection/rebilling, collect coinsurance payments or deductibles, postcertify patient).

During the second round of the CPEPs, Abt collected the inputs by the broader category of service. For example, for additional evaluation and management services codes in the same family as the reference code, Abt collected totals on clinical times for the preservice period, the intraservice period, and the postservice period. Similarly, the same process was followed for administrative inputs. This less detailed, more aggregated, process was used because of the large volume of procedure codes the CPEPs had to review during the second round and because the CPEPs believed this level of detail was sufficient.

b. Pricing of Clinical Practice Expert Panels' Direct Inputs

Having identified the type and quantity of direct inputs from the CPEP process, our methodology required the assignment of a national price for each resource input. Abt priced each of the CPEP direct inputs (nonphysician labor, medical supplies, and medical equipment) using a specific methodology. The methodology for each of these items is discussed below.

(1) Nonphysician Labor

Abt calculated the total compensation per minute for approximately 100 occupational categories that include clinical and administrative staff. The data sources for these staff identified hourly wages, including fringe benefits, per person for 1993 or 1994. These wages were updated to 1995 using the Employment Cost Index for Wages and Salaries in Private Health Industries (published by the Bureau of Labor Statistics). They were converted to total compensation by adjusting the wage rate by a fringe benefits multiplier. The fringe benefits multiplier is 36.6 percent for all occupational categories. This is estimated from the Bureau of Labor Statistics Employer Costs for Employee Compensation for March 1995. Abt calculated the fringe benefit multiplied from the Bureau of Labor Statistics data using the ratio of the total cost of all benefits to the wage rate for all workers in private health services industries.

Three specific data sources were used. They were: (1) The Bureau of Labor Statistics' ''White Collar Pay Survey of Service-Producing Industries'' dated 1989 and the ''Occupational Compensation Survey'' dated 1994; (2) ''The Survey of Hospital and Medical School Salaries'' dated 1994 performed by the University of Texas Medical Branch; and (3) the Current Population Survey dated 1993. Although all three data sources were used, in cases of similar categories across data sets, the Bureau of Labor Statistics data were considered to be the primary data set. The University of Texas Medical Branch and Current Population Survey data were treated as supplements to be used when the Bureau of Labor Statistics' data could not furnish sufficient detail.

Abt categorized all personnel into five broad categories: clinical staff, administrative staff, clinical composite staff, administrative composite staff, and clinical/administrative composite staff. The administrative composite staff refers, for example, to a function described by a CPEP that could be performed by different personnel. A composite labor rate was calculated for this function for this CPEP.

We use the occupational category of the medical secretary to illustrate the mapping of the price for an administrative staff position. Every CPEP reported that a medical secretary performed certain functions as part of the procedure codes reviewed by that CPEP. From the Bureau of Labor Statistics' data, the updated 1995 total compensation, including fringe benefits, for a level II medical secretary is $16.43 per hour. (The Bureau of Labor Statistics furnishes skilled level variations in wages and duties for registered nurses, licensed practical nurses, secretaries, office clerks, and nursing assistants. In general, as we advised, Abt used the Bureau of Labor Statistics' wage for level II staff.) This converts to a total compensation per minute of $0.274 for a medical secretary, and this labor rate was made uniform across all CPEPs. If, for example, a CPEP specified that a medical secretary was needed for 10 minutes to provide administrative services for a specific CPT code, that labor input would be costed at $2.74.

Similarly, we use the occupational category of a registered nurse to illustrate the mapping of the price for a clinical staff position. Every CPEP, except the gastroenterology CPEP, reported that a registered nurse performed certain functions with respect to the procedure codes reviewed by that CPEP. The hourly wage for a level II registered nurse was $18.52 under the Bureau of Labor Statistics' survey. The total compensation, including fringe benefits, for a registered nurse is $25.30 per hour. This converts to a total compensation per minute of $0.422. Thus, for each CPEP, the minutes of a registered nurse's time are costed at $0.422. If, for example, a CPEP specified that a registered nurse was needed for 10 minutes to provide clinical services for a specific CPT code for a patient, that direct input would be costed at $4.22.

(2) Medical Supplies

Overall, the CPEPs identified 665 supply items for which Abt obtained prices from three types of sources:

- Published catalogs—These were used for the most common supplies and CPEP panelists often provided recommendations of catalogs or other sources.
- Contacts with suppliers—This source was used primarily for specialized supplies.
- CPEP members—This source was used if prices were unavailable from catalogs or suppliers.

Examples of medical supplies include disposable gowns, examination table paper, disposable pillow cases, nonsterile or sterile gloves, disposable suture removal kit, Vicryl suture, 4–0 and 5–0, and sterile gauze. Abt used the same prices for these supplies across all CPEPs. For example, for all CPEPs, the

price of the disposable gown is $0.57 per item and is based on a representative price from Baxter Healthcare Corporation, a major medical supplier. Similarly, the price of the disposable suture removal kit for all CPEPs is $5.45 per kit and is based on a representative price from Darby Drug Company.

(3) Medical Equipment

Medical equipment was divided into two categories—procedure-specific equipment and overhead equipment. Procedure-specific medical equipment is used for a specific subset of services within a specialty, such as a stress-test treadmill as part of a cardiology procedure. Overhead medical equipment is either used for all services furnished or is rarely used (for example, a crash cart containing emergency supplies) but is routinely purchased and maintained in a practice and is difficult to attribute to a specific service. Only equipment with costs equal to or exceeding $500 was costed under the medical equipment methodology. The cost per use for equipment costing less than $500 was considered to be trivial.

Information about the type of equipment used to furnish each service was obtained from the CPEPs. Abt applied price data to the resource profiles generated by the CPEPs. In most cases, Abt collected list prices from equipment suppliers. For example, the list price for a flexible laryngoscope is $5,080 (this information is from Welch-Allyn, a medical equipment supplier). Prices were obtained for almost 400 equipment items.

To cost procedure-specific and overhead equipment, Abt assumed 70-percent and 100-percent utilization rates, respectively. Based on comments from the physician specialty groups, we have changed the utilization level for procedure-specific equipment from 70 percent to 50 percent.

Procedure-specific equipment was costed based on the number of minutes the equipment was used for the procedure. The proxy for this is usually technician time. Overhead equipment was costed based on the estimated time for the staff with the most involvement in the procedure. For example, if a procedure involving a piece of equipment was performed in the office and involved 15 minutes of registered nurse time and 30 minutes of physician assistant time, the time of the procedure would be 30 minutes since this is the longest of the nonphysician clinical staff times.

The objective in pricing medical equipment was to establish an equipment cost per minute. The equipment pricing model uses the following variables:

- The purchase price of the equipment with primary sources of information from national manufacturers.
- The useful life of the equipment with primary sources of information from ''Useful Life Guidelines'' from the American Hospital Association.
- The annual maintenance cost with primary sources of information from the Medical Group Management Association.
- The cost of capital.
- The time per procedure with primary sources of information from CPEP labor estimates.
- The hours of practice (that is, 50 hours per week and 50 weeks per year) with primary sources of information from the Medical Group Management Association and the AMA.
- The machine capacity, based on a practice's hours, with the assumption that the equipment operates at a fixed percentage (in this case 50 percent) of capacity.

Ideally, a cost of capital would be established from a nationally representative sample of data containing loan rates and length of loan for physician practices. Such data do not exist. As a result, Abt developed proxy data based on prevailing loan rates for small businesses. In this model, interest rates varied by the loan period (one rate for periods less than or equal to 7 years and another for periods greater than 7 years) and based on the purchase price of the equipment (one rate for equipment costing less than or equal to $25,000 and another for equipment costing more than $25,000).

Amount	Interest rate (percent)	
	Loan period ≤7 years	Loan period >7 Years
>$25,000	9.5	10.
≤$25,000	10.5	11

For example, the cost of capital for an item of medical equipment costing more than $25,000 and with a useful life less than 7 years was assigned an interest rate of 9.5 percent.

The following example illustrates the application of the pricing model for equipment that is used to perform only one type of procedure code, assuming the following:

- The equipment is operated at 50 percent of capacity.
- The practice operates 50 hours per week or 105,000 minutes per year (60 minutes/hour×50 hours/week×50 weeks/year×.50=75,000 minutes).
- The cost of capital (that is, the interest cost of a loan or opportunity cost of invested funds is 9.5 percent).
- The purchase price of the equipment is $30,000.
- The useful life of the equipment is 5 years.
- The annual maintenance costs are 5 percent of the annual purchase price (.05×$30,000) or $1,500.
- The procedure performed on the equipment takes 10 minutes.

Cost per procedure=10×[$30,000/(75,000×3.8397)+1,500/75,000]
Cost per procedure=$1.24

Note: 3.38397 represents $\Sigma 1/(1+r)^t$ where t=0 to 5. The cost of capital is discounted by the number of years of useful life. The annualized capitalized cost for the equipment is $9,313, which is the annual maintenance cost of $1,500, plus the annualized purchase price ($7,813), taking into account the opportunity cost of capital or $30,000 divided by 3.8397.

Addendum B. Resource Based Practice Expense Methodology and Example

Step 1: By specialty, use the American Medical Association's Socioeconomic Monitoring Survey actual cost data for 1995–1997 (SMS data) to determine practice expenses per hour by cost category.

Methodology

(1) Derive the expenses at the physician practice level using the SMS data by cost category. The cost categories are:

(a) total non-physician payroll expenses, which are payroll expenses (including fringe benefits) for non-physician personnel;

(b) administrative payroll expenses, which are payroll expenses (including fringe benefits) for non-physician personnel involved in administrative, secretarial, or clerical activities;

(c) office expenses, which include expenses for rent, mortgage interest, depreciation on medical buildings, utilities, and telephone;

(d) medical material and supply expenses, which include expenses for drugs, x-ray films, and disposable medical products;

(e) medical equipment expenses, which include expenses for depreciation, leases, and rent of medical equipment used in the diagnosis or treatment of patients;

(f) all other expenses, which include expenses for legal services, accounting services, office management services, professional association memberships, journals and continuing education, professional car upkeep and depreciation, and any professional expenses not mentioned above.

We refer to the difference between the total nonphysician payroll expense category and the clerical payroll expense category as the clinical payroll expense category.

(2) Derive the number of hours spent in patient care activities by physicians in the practice.

(3) Divide the expenses at the practice level by the number of hours spent in patient care activities by the physicians in the practice.

Derivations

$$\text{Practice expenses per hour for cost category x of specialty j} = PEHR_{x,j} = \frac{\sum_i \frac{\left(pe_{i,j,x} * o_{i,j}\right)}{\left(rh_{i,j} * o_{i,j}\right) + \left(e_{i,j} * eh_j\right)} * w_{i,j}}{\sum_i w_{i,j}}$$

i,j = respondent physician i of specialty j

$pe_{i,j,x}$ = category x practice expenses for respondent i of specialty j

$o_{i,j}$ = number of physician owners in the practice of respondent i of specialty j

$rh_{i,j}$ = number of hours worked in patient care activities during the year by respondent i of specialty j

$e_{i,j}$ = number of employee physicians in the practice of respondent i of specialty j

eh_j = average number of hours worked in patient care activities for employee physician's in specialty j

$w_{i,j}$= SMS weight for respondent i of specialty j to correct for potential nonresponse bias

Step 2: By specialty, determine the number of physician hours spent treating Medicare patients as reflected in the Medicare claims data.

Methodology

By specialty, determine the number of physician hours reflected in the Medicare physician fee schedule claims data as a weighted sum of the physician time associated with each procedure code on the fee schedule.

$$\text{physician hours for specialty j} = HOURS_J = \sum_k \left(t_k * f_{k,j}\right)$$

K = procedure code performed by specialty j

t_k = the physician time associated with procedure k, taken primarily from the AMA Relative Value Update committee surveys (where available) or surveys done for the initial establishment of the work relative value units

$f_{k,j}$ = the frequency with which procedure code k is performed on Medicare patients by the physicians in specialty j as reflected in the Medicare allowed claims data

Step 3: By specialty, multiply the SMS practice expenses per hour for each cost category (as calculated in Step 1) by the number of physician hours reflected in the Medicare physician fee schedule claims data (as calculated in Step 2).

Methodology

$$\text{The practice expense pool for cost category x of specialty j} = POOL_{X,J} = PEHR_{x,j} * HOURS_J$$

calculated for each × from 1 to 4, with 1 = clinical payroll expense, 2 = medical materials and supplies expense, 3 = medical equipment expense, 4 = a combined category of clerical payroll expense, office expense, and all other expenses.

Step 4: For each specialty and cost category, allocate the practice expense pool calculated in Step 3 to the procedures performed by that specialty.

Methodology

(1) Clinical payroll expense, medical materials and supplies, and medical equipment SMS pools.

The CPEP cost categories of clinical labor, medical supplies, and medical equipment in the facility and nonfacility place of service settings are used to allocate, respectively, the SMS cost category pools for clinical payroll expense, medical materials and supplies, and medical equipment.

$$\text{Practice expense pool allocation for category x to procedure code k for specialty j in place of service p} = costs_{x,k,j,p} = cpep_{x,k,p} * \frac{POOL_{x,j}}{\sum_k \sum_p cpep_{x,k,p} * f_{k,j,p}}$$

p = place of service where the procedure is performed with p=1 the facility setting (eg hospital) and p=2 the nonfacility setting (eg physician's office)

$cpep_{x,k,p}$ = CPEP costs for category x for procedure code k in setting p (procedure codes costed in a setting as nonzero by more than one CPEP are averaged)

$f_{k,j,p}$ = the frequency with which procedure code k was performed in place of service p on Medicare patients by the physicians in

specialty j as reflected in the Medicare allowed claims data

calculate for each × from 1 to 3

(2) Administrative payroll expense, office expense, and other expense SMS pools.

A combination of the clinical payroll, medical materials and supplies, and medical equipment code allocations calculated in (1) and the physician fee schedule work relative value units are used to allocate the combined SMS cost category pool for administrative payroll expense, office expense, and other expense (category 4).

$$\text{Practice expense pool allocation for category 4 to procedure code k for specialty j in setting p} = \text{costs}_{4,k,j,p} = \left[\left(\sum_{x=1}^{3}\text{costs}_{x,k,j,p}\right) + \left(w_k * s\right)\right] * \frac{\text{POOL}_{x,j}}{\sum_k \sum_p \left[\left(\left(\sum_{x=1}^{3}\text{costs}_{x,k,j,p}\right) + \left(w_k * s\right)\right) * f_{k,j,p}\right]}$$

w_k = the work relative value units for procedure code k

s = factor to convert work relative value units to SMS category pool dollars

Step 5: Weight average the allocations calculated in Step 4 to account for procedure codes performed by more than one specialty.

Methodology

For procedure codes performed by only one specialty, use that specialty's allocation. For procedure codes performed by more than one specialty, take a weighted average of the allocations for the specialties which perform the procedure, where the weight is the frequency with which the procedure is performed by that specialty.

Practice expense pool allocation for category x to procedure code k in place of service p = $\text{costs}_{x,k,p}$ =

$$\text{Practice expense pool allocation for category x to procedure code k in place of service p} = \text{costs}_{x,k,p} = \frac{\sum_j \left(\text{costs}_{x,j,k,p} * f_{k,j,p}\right)}{\sum_j f_{k,j,p}}$$

Step 6: From the allocations calculated in Step 5, create the new practice expense relative units by place of service for each procedure code.

Methodology

For each procedure code, multiply the sum of the allocations from Step 5 for the four cost categories by the ratio of the available pool of practice expense relative value units to the weighted sum of all the procedure code allocations. Although not illustrated below, procedure codes with professional and technical components were adjusted as described earlier in this **Federal Register** notice to ensure that the technical and professional components sum to the global for the service. New practice expense relative value unit for procedure code k in place of service p = $\text{rvunew}_{k,p}$ =

$$\text{new practice expense relative value unit for procedure code k in place of service p} = \text{rvunew}_{k,p} = \sum_x \text{costs}_{x,k,p} * \frac{\sum_k \sum_p \left(\text{rvuold}_{k,p} * f_{k,p}\right)}{\sum_k \sum_p \left(\left(\sum_x \text{costs}_{x,k,p}\right) * f_{k,p}\right)}$$

Example

The following example is designed to illustrate the resource based practice expense methodology described above. For simplicity, the entire Medicare physician fee schedule universe is assumed to consist of two specialties and six procedure codes. This example does not yield the actual resource based practice expense relative value units found in Addendum C for the six codes.

BILLING CODE 4120–03–P

TABLE 1

Step 1: Results of practice expense per hour derivation

	(A)	(B)	(C)	(D)	(E)	(F)	(G)
	Practice Expenses per Hour						
	Clinical Payroll	Medical Materials and Supplies	Medical Equipment	Administrative Payroll	Office Expenses	All Other Expenses	Total*
Family Practice	$15.10	$8.10	$3.60	$15.10	$18.20	$8.60	$68.60
General Surgery	$6.80	$3.10	$2.00	$15.70	$17.20	$9.40	$54.10

*Components may not add to totals due to rounding

TABLE 2

Step 2: Determine the number of hours spent treating Medicare patients as reflected in Medicare claims data

Specialty	CPT	Description	(A) Physician Time for Procedure (mins)	(B) Physician Time for Procedure (hours)	(C) Medicare Frequency	(D) Total Physician Time (hours)
Family Practice						
	99213	Office/outpatient visit, est	23	0.38	17,720,998	6,793,049
	99232	Subsequent hospital care	30	0.50	3,558,740	1,779,370
					Total	8,572,419
General Surgery						
	35301	Rechanneling of artery	390	6.50	35,239	229,054
	44140	Sigmoidoscopy, diagnostic	511	8.52	47,620	405,564
	45330	Partial removal of colon	28	0.47	48,815	22,780
	56340	Laparoscopic cholecystectomy	313	5.22	79,501	414,730
	99213	Office/outpatient visit, est	23	0.38	1,691,272	648,321
	99232	Subsequent hospital care	30	0.50	566,202	283,101
					Total	2,003,550

Notes:
(B) = (A) / 60
(D) = (B) * (C)

TABLE 3

Step 3: Multiply practice expenses per hour (from Step 1) by the number of physician hours (from Step 2)

	(A)	(B)	(C)	(D)	(E)
	Practice Expenses per Hour				Total Physician Time (hours)
	Clinical Payroll	Medical Materials and Supplies	Medical Equipment	Administrative Payroll, Office, and all other	
Family Practice	$15.10	$8.10	$3.60	$41.90	8,572,419
General Surgery	$6.80	$3.10	$2.00	$42.30	2,003,550

	(F)	(G)	(H)	(I)	(J)
	Practice Expense Pool				
	Clinical Payroll	Medical Materials and Supplies	Medical Equipment	Administrative Payroll, Office, and all other	Total
Family Practice	$129,443,530	$69,436,596	$30,860,709	$359,184,366	$588,925,201
General Surgery	$13,624,138	$6,211,004	$4,007,099	$84,750,150	$108,592,391
				Total	$697,517,592

Notes:
(D) = TABLE 1 COL (D) + TABLE 1 COL (E) + TABLE 1 COL (F)
(E) = TABLE 2 COL (D) "TOTAL"
(F) = (A) * (E)
(G) = (B) * (E)
(H) = (C) * (E)
(I) = (D) * (E)
(J) = (F) + (G) + (H) + (I)

TABLE 4

Step 4(1): For clinical, supplies, and equipment, allocate the practice expense pool calculated in Step 3 to the procedure codes

	CPEP Data					
	(A)	(B)	(C)	(D)	(E)	(F)
	CPEP Facility Data			CPEP Nonfacility Data		
	Clinical	Supplies	Equipment	Clinical	Supplies	Equipment
35301	$144.94	$1.04	$13.97			
44140	$188.13	$1.21	$12.74			
45330	$4.76	$0.00	$0.00	$28.85	$5.47	$116.12
56340	$96.30	$0.86	$8.68			
99213	$8.15	$0.00	$0.00	$16.43	$0.77	$2.85
99232	$3.72	$0.00	$0.00			

TABLE 5

Step 4(1) cont. : For clinical, supplies, and equipment, allocate the practice expense pool calculated in Step 3 to the procedure codes

		Medicare Frequency Data		
		(A)	(B)	(C)
		Medicare Frequency		
Specialty	CPT	Facility	Nonfacility	Total
Family Practice				
	99213	420,181	17,300,817	17,720,998
	99232	3,558,740	0	3,558,740
General Surgery				
	35301	35,239	0	35,239
	44140	47,620	0	47,620
	45330	19,406	29,409	48,815
	56340	79,501	0	79,501
	99213	49,952	1,641,320	1,691,272
	99232	566,202	0	566,202
		470,133	18,942,137	19,412,270
		4,124,942	0	4,124,942
				23,537,212

TABLE 6

Step 4(1) cont. : For clinical, supplies, and equipment, allocate the practice expense pool calculated in Step 3 to the procedure codes

CPEP Data * Medicare Frequency

	(A)	(B)	(C)	(D)	(E)	(F)
	CPEP Facility Data *Medicare Freq			CPEP Nonfacility Data *Medicare Freq		
	Clinical	Supplies	Equipment	Clinical	Supplies	Equipment
Family Practice						
99213	$3,424,055	$0	$0	$284,326,950	$13,272,388	$49,323,188
99232	$13,237,623	$0	$0			
General Surgery						
35301	$5,107,682	$36,596	$492,130			
44140	$8,958,751	$57,715	$606,822			
45330	$92,276	$0	$0	$848,361	$160,729	$3,414,885
56340	$7,656,105	$67,973	$689,989			
99213	$407,059	$0	$0	$26,973,958	$1,259,145	$4,679,267
99232	$2,106,130	$0	$0			

Notes:
(A) = TABLE 4 COL (A) * TABLE 5 COL (A)
(B) = TABLE 4 COL (B) * TABLE 5 COL (A)
(C) = TABLE 4 COL (C) * TABLE 5 COL (A)
(D) = TABLE 4 COL (D) * TABLE 5 COL (B)
(E) = TABLE 4 COL (E) * TABLE 5 COL (B)
(F) = TABLE 4 COL (F) * TABLE 5 COL (B)

TABLE 7

Step 4(1) cont. : For clinical, supplies, and equipment, allocate the practice expense pool calculated in Step 3 to the procedure codes

Calculate Ratios

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)
	Sum Table 6 Facility and Nonfacility			Table 3 Practice Expense Pool			Ratio		
	Clinical	Supplies	Equipment	Clinical Payroll	Medical Mat. and Supplies	Medical Equipment	Clinical Payroll	Medical Mat. and Supplies	Medical Equipment
Family Practice									
99213	$287,751,005	$13,272,388	$49,323,188						
99232	$13,237,623	$0	$0						
Total	$300,988,628	$13,272,388	$49,323,188	$129,443,530	$69,436,596	$30,860,709	0.430	5.232	0.626
General Surgery									
35301	$5,107,682	$36,596	$492,130						
44140	$8,958,751	$57,715	$606,822						
45330	$940,637	$160,729	$3,414,885						
56340	$7,656,105	$67,973	$689,989						
99213	$27,381,017	$1,259,145	$4,679,267						
99232	$2,106,130	$0	$0						
Total	$52,150,321	$1,582,158	$9,883,092	$13,624,138	$6,211,004	$4,007,099	0.261	3.926	0.405

Notes:
(A) = TABLE 6 COL (A) + TABLE 6 COL (D)
(B) = TABLE 6 COL (B) + TABLE 6 COL (E)
(C) = TABLE 6 COL (C) + TABLE 6 COL (F)
(G) = (D) / (A)
(H) = (E) / (B)
(I) = (F) / (C)

TABLE 8

Step 4(1) cont. : For clinical, supplies, and equipment, allocate the practice expense pool calculated in Step 3 to the procedure codes

Apply Ratios to CPEP Data

	(A)	(B)	(C)	(D)	(E)	(F)
	CPEP Facility Data * Ratio			CPEP Nonfacility Data * Ratio		
	Clinical	Supplies	Equipment	Clinical	Supplies	Equipment
Family Practice						
99213	$3.50	$0.00	$0.00	$7.07	$4.01	$1.78
99232	$1.60	$0.00	$0.00			
General Surgery						
35301	$37.87	$4.08	$5.66			
44140	$49.15	$4.76	$5.17			
45330	$1.24	$0.00	$0.00	$7.54	$21.45	$47.08
56340	$25.16	$3.36	$3.52			
99213	$2.13	$0.00	$0.00	$4.29	$3.01	$1.16
99232	$0.97	$0.00	$0.00			

Notes:
(A) = TABLE 4 COL (A) * TABLE 7 COL (G)
(B) = TABLE 4 COL (B) * TABLE 7 COL (H)
(C) = TABLE 4 COL (C) * TABLE 7 COL (I)
(D) = TABLE 4 COL (D) * TABLE 7 COL (G)
(E) = TABLE 4 COL (E) * TABLE 7 COL (H)
(F) = TABLE 4 COL (F) * TABLE 7 COL (I)

TABLE 9

Step 4(2) : For category 4, allocate the practice expense pool calculated in Step 3 to the procedure codes

Determine the Pool 4 Allocators

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)
	Table 8 Facility			Table 8 Nonfacility						Pool 4 Allocators	
	Clinical	Supplies	Equip	Clinical	Supplies	Equip	Work RVU	Factor to Convert	Work RVU Converted	Facility	Nonfacility
Family Practice											
99213	$3.50	$0.00	$0.00	$7.07	$4.01	$1.78	0.67	$58.99	$39.53	$43.03	$52.39
99232	$1.60	$0.00	$0.00				1.06	$58.99	$62.53	$64.13	
General Surgery											
35301	$37.87	$4.08	$5.66				18.70	$58.99	$1,103.21	$1,150.81	
44140	$49.15	$4.76	$5.17				18.35	$58.99	$1,082.56	$1,141.63	
45330	$1.24	$0.00	$0.00	$7.54	$21.45	$47.08	0.96	$58.99	$56.64	$57.88	$132.71
56340	$25.16	$3.36	$3.52				11.09	$58.99	$654.25	$686.29	
99213	$2.13	$0.00	$0.00	$4.29	$3.01	$1.16	0.67	$58.99	$39.53	$41.66	$47.99
99232	$0.97	$0.00	$0.00				1.06	$58.99	$62.53	$63.51	

Notes:
(H) = TABLE 3 COL (J) "TOTAL" / TABLE 12 COL (L) "TOTAL 2"
(I) = (G) * (H)
(J) = (A) + (B) + (C) + (I)
(K) = (D) + (E) + (F) + (I) if applicable to nonfacility

TABLE 10

Step 4(2) cont : For category 4, allocate the practice expense pool calculated in Step 3 to the procedure codes

Calculate Pool 4 Allocation

		(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
		Medicare Frequency			Pool 4 Allocators		Allocators *	Pool 4 Allocation	
Specialty	CPT	Facility	Nonfacility	Total	Facility	Nonfacility	Medicare Freq	Facility	Nonfacility
Family Practice									
	99213	420,181	17,300,817	17,720,998	$43.03	$52.39	$924,499,497	$13.41	$16.32
	99232	3,558,740	0	3,558,740	$64.13		$228,237,715	$19.98	
						Total	$1,152,737,212		
						Pool 4	$359,184,366		
						Ratio	0.3116		
General Surgery									
	35301	35,239	0	35,239	$1,150.81		$40,553,457	$359.49	
	44140	47,620	0	47,620	$1,141.63		$54,364,478	$356.62	
	45330	19,406	29,409	48,815	$57.88	$132.71	$5,025,916	$18.08	$41.45
	56340	79,501	0	79,501	$686.29		$54,560,622	$214.38	
	99213	49,952	1,641,320	1,691,272	$41.66	$47.99	$80,843,708	$13.01	$14.99
	99232	566,202	0	566,202	$63.51		$35,957,491	$19.84	
						Total	$271,305,673		
						Pool 4	$84,750,150		
						Ratio	0.3124		

Notes:
(F) = [(A) * (D)] + [(B) * (E)]
(G) = (D) * [(F) "Ratio"]
(H) = (E) * [(F) "Ratio"] ,

TABLE 11

Step 5: Weight average the allocations from Step 4

	Facility				Nonfacility				Medicare Frequency	
	Table 8			Table 10	Table 8			Table 10		
	Clinical	Supplies	Equip	Pool 4	Clinical	Supplies	Equip	Pool 4	Facility	Nonfacility
Family Practice										
99213	$3.50	$0.00	$0.00	$13.41	$7.07	$4.01	$1.78	$16.32	420,181	17,300,817
99232	$1.60	$0.00	$0.00	$19.98					3,558,740	0
General Surgery										
35301	$37.87	$4.08	$5.66	$359.49					35,239	0
44140	$49.15	$4.76	$5.17	$356.62					47,620	0
45330	$1.24	$0.00	$0.00	$18.08	$7.54	$21.45	$47.08	$41.45	19,406	29,409
56340	$25.16	$3.36	$3.52	$214.38					79,501	0
99213	$2.13	$0.00	$0.00	$13.01	$4.29	$3.01	$1.16	$14.99	49,952	1,641,320
99232	$0.97	$0.00	$0.00	$19.84					566,202	0

Weighted Average					Total Facility					Total Nonfacility
35301	$37.87	$4.08	$5.66	$359.49	$407.09					
44140	$49.15	$4.76	$5.17	$356.62	$415.69					
45330	$1.24	$0.00	$0.00	$18.08	$19.32	$7.54	$21.45	$47.08	$41.45	$117.53
56340	$25.16	$3.36	$3.52	$214.38	$246.42					
99213	$3.36	$0.00	$0.00	$13.37	$16.72	$6.77	$3.91	$1.72	$16.18	$28.58
99232	$1.51	$0.00	$0.00	$19.96	$21.48					

TABLE 12

Step 6: Create New Practice Expense Relative Value Units

	(A)	(B)	(C)	(D)	(E)	(F)
	Total from Table 11		1998 PERVU		Medicare Frequency	
	Facility	Nonfacility	Facility	Nonfacility	Facility	Nonfacility
35301	$407.09		14.46	14.46	35,239	0
44140	$415.69		11.37	11.37	47,620	0
45330	$19.32	$117.53	0.53	1.23	19,406	29,409
56340	$246.42		7.99	7.99	79,501	0
99213	$16.72	$28.58	0.19	0.43	470,133	18,942,137
99232	$21.48		0.45	0.45	4,124,942	0

	(G)	(H)	(I)	(J)	(K)	(L)
	Total from Table 11 * Medicare Freq			1998 PERVU* Medicare Freq		
	Facility	Nonfacility	Total	Facility	Nonfacility	Total
35301	$14,345,607		$14,345,607	509,556	0	509,556
44140	$19,795,370		$19,795,370	541,439	0	541,439
45330	$374,961	$3,456,297	$3,831,258	10,285	36,173	46,458
56340	$19,590,317		$19,590,317	635,213	0	635,213
99213	$7,862,762	$541,368,781	$549,231,542	89,325	8,145,119	8,234,444
99232	$88,592,748		$88,592,748	1,856,224	0	1,856,224
		Total 1	$695,386,842		Total 2	11,823,335
					Ratio = Total 2 / Total 1 =	0.017

	(M)	(N)
	New RVUPE=Total from Table 11 * Ratio	
	Facility	Nonfacility
35301	6.92	
44140	7.07	
45330	0.33	2.00
56340	4.19	
99213	0.28	0.49
99232	0.37	

Notes:
(C) = 1998 PERVU with 50% reduction for current SOS policy where applicable
(G) = (A) * (E)
(H) = (B) * (F)
(I) = (G) + (H)
(J) = (C) * (E)
(K) = (D) * (F)
(L) = (J) + (K)
(M) = (A) * [(L) "Ratio"]
(N) = (B) * [(L) "Ratio"]

BILLING CODE 4120–03–C

ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
10040	.....	A	Acne surgery of skin abscess	1.18	1.47	4.46	0.03	2.68	15.78	010
10060	.....	A	Drainage of skin abscess	1.17	0.86	0.52	0.04	2.07	1.73	010
10061	.....	A	Drainage of skin abscess	2.40	1.49	1.06	0.06	3.95	3.52	010
10080	.....	A	Drainage of pilonidal cyst	1.17	1.41	0.51	0.05	2.63	1.73	010
10081	.....	A	Drainage of pilonidal cyst	2.45	1.95	1.25	0.16	4.56	3.86	010
10120	.....	A	Remove foreign body	1.22	1.23	0.48	0.05	2.50	1.75	010
10121	.....	A	Remove foreign body	2.69	2.08	1.35	0.12	4.89	4.16	010
10140	.....	A	Drainage of hematoma/fluid	1.53	0.94	0.79	0.05	2.52	2.37	010
10160	.....	A	Puncture drainage of lesion	1.20	1.07	0.61	0.05	2.32	1.86	010

[1] CPT codes and descriptions only are copyright 1997 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 1994 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not for Medicare Payment.

ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
10180	.....	A	Complex drainage, wound	2.25	1.17	1.18	0.18	3.60	3.61	010
11000	.....	A	Debride infected skin	0.60	0.37	0.24	0.04	1.01	0.88	000
11001	.....	A	Debride infect skin add	0.30	0.20	0.13	0.02	0.52	0.45	ZZZ
11010	.....	A	Debride skin, fx	4.20	2.01	1.78	0.65	6.86	6.63	010
11011	.....	A	Debride skin/muscle, fx	4.95	2.88	2.44	0.77	8.60	8.16	000
11012	.....	A	Debride skin/muscle/bone, fx	6.88	3.82	3.58	1.07	11.77	11.53	000
11040	.....	A	Debride skin partial	0.50	0.32	0.20	0.04	0.86	0.74	000
11041	.....	A	Debride skin full	0.82	0.47	0.35	0.06	1.35	1.23	000
11042	.....	A	Debride skin/tissue	1.12	0.68	0.48	0.08	1.88	1.68	000
11043	.....	A	Debride tissue/muscle	2.38	1.79	1.30	0.34	4.51	4.02	010
11044	.....	A	Debride tissue/muscle/bone	3.06	2.35	1.77	0.49	5.90	5.32	010
11055	.....	R	Trim skin lesion	0.27	0.32	0.12	0.02	0.61	0.41	000
11056	.....	R	Trim 2 to 4 skin lesions	0.39	0.36	0.17	0.03	0.78	0.59	000
11057	.....	R	Trim over 4 skin lesions	0.50	0.41	0.22	0.03	0.94	0.75	000
11100	.....	A	Biopsy of skin lesion	0.81	1.26	0.73	0.04	2.11	1.58	000
11101	.....	A	Biopsy, each added lesion	0.41	0.72	0.53	0.02	1.15	0.96	ZZZ
11200	.....	A	Removal of skin tags	0.77	1.72	0.56	0.04	2.53	1.37	010
11201	.....	A	Removal of added skin tags	0.29	0.69	0.67	0.02	1.00	0.98	ZZZ
11300	.....	A	Shave skin lesion	0.51	1.04	0.70	0.05	1.60	1.26	000
11301	.....	A	Shave skin lesion	0.85	1.10	0.95	0.06	2.01	1.86	000
11302	.....	A	Shave skin lesion	1.05	1.19	1.13	0.09	2.33	2.27	000
11303	.....	A	Shave skin lesion	1.24	1.34	1.29	0.17	2.75	2.70	000
11305	.....	A	Shave skin lesion	0.67	0.81	0.75	0.05	1.53	1.47	000
11306	.....	A	Shave skin lesion	0.99	1.06	1.01	0.07	2.12	2.07	000
11307	.....	A	Shave skin lesion	1.14	1.15	1.12	0.10	2.39	2.36	000
11308	.....	A	Shave skin lesion	1.41	1.21	1.30	0.17	2.79	2.88	000
11310	.....	A	Shave skin lesion	0.73	1.11	0.83	0.06	1.90	1.62	000
11311	.....	A	Shave skin lesion	1.05	1.21	1.12	0.08	2.34	2.25	000
11312	.....	A	Shave skin lesion	1.20	1.27	1.28	0.11	2.58	2.59	000
11313	.....	A	Shave skin lesion	1.62	1.62	1.57	0.15	3.39	3.34	000
11400	.....	A	Removal of skin lesion	0.91	1.57	0.60	0.05	2.53	1.56	010
11401	.....	A	Removal of skin lesion	1.32	1.65	0.77	0.06	3.03	2.15	010
11402	.....	A	Removal of skin lesion	1.61	1.77	0.86	0.09	3.47	2.56	010
11403	.....	A	Removal of skin lesion	1.92	1.67	0.99	0.13	3.72	3.04	010
11404	.....	A	Removal of skin lesion	2.20	1.81	1.10	0.17	4.18	3.47	010
11406	.....	A	Removal of skin lesion	2.76	2.42	1.33	0.33	5.51	4.42	010
11420	.....	A	Removal of skin lesion	1.06	1.33	0.68	0.05	2.44	1.79	010
11421	.....	A	Removal of skin lesion	1.53	1.62	0.90	0.07	3.22	2.50	010
11422	.....	A	Removal of skin lesion	1.76	1.75	0.97	0.10	3.61	2.83	010
11423	.....	A	Removal of skin lesion	2.17	1.77	1.14	0.15	4.09	3.46	010
11424	.....	A	Removal of skin lesion	2.62	1.97	1.33	0.16	4.75	4.11	010
11426	.....	A	Removal of skin lesion	3.78	2.86	1.83	0.29	6.93	5.90	010
11440	.....	A	Removal of skin lesion	1.15	1.72	0.82	0.06	2.93	2.03	010
11441	.....	A	Removal of skin lesion	1.61	1.85	1.05	0.08	3.54	2.74	010
11442	.....	A	Removal of skin lesion	1.87	1.96	1.14	0.11	3.94	3.12	010
11443	.....	A	Removal of skin lesion	2.49	2.39	1.47	0.15	5.03	4.11	010
11444	.....	A	Removal of skin lesion	3.42	2.60	1.96	0.14	6.16	5.52	010
11446	.....	A	Removal of skin lesion	4.49	3.52	2.47	0.18	8.19	7.14	010
11450	.....	A	Removal, sweat gland lesion	2.73	5.45	1.79	0.44	8.62	4.96	090
11451	.....	A	Removal, sweat gland lesion	3.95	7.23	2.48	0.46	11.64	6.89	090
11462	.....	A	Removal, sweat gland lesion	2.51	5.50	1.83	0.36	8.37	4.70	090
11463	.....	A	Removal, sweat gland lesion	3.95	6.91	2.02	0.34	11.20	6.31	090
11470	.....	A	Removal, sweat gland lesion	3.25	6.63	1.90	0.45	10.33	5.60	090
11471	.....	A	Removal, sweat gland lesion	4.41	7.55	2.63	0.48	12.44	7.52	090
11600	.....	A	Removal of skin lesion	1.41	1.75	0.84	0.10	3.26	2.35	010
11601	.....	A	Removal of skin lesion	1.93	2.67	1.11	0.12	4.72	3.16	010
11602	.....	A	Removal of skin lesion	2.09	1.91	1.17	0.16	4.16	3.42	010
11603	.....	A	Removal of skin lesion	2.35	1.86	1.25	0.21	4.42	3.81	010
11604	.....	A	Removal of skin lesion	2.58	1.99	1.35	0.26	4.83	4.19	010
11606	.....	A	Removal of skin lesion	3.43	2.74	1.68	0.49	6.66	5.60	010
11620	.....	A	Removal of skin lesion	1.34	1.71	0.87	0.12	3.17	2.33	010
11621	.....	A	Removal of skin lesion	1.97	1.88	1.20	0.16	4.01	3.33	010
11622	.....	A	Removal of skin lesion	2.34	2.06	1.34	0.19	4.59	3.87	010
11623	.....	A	Removal of skin lesion	2.93	2.17	1.59	0.25	5.35	4.77	010
11624	.....	A	Removal of skin lesion	3.43	2.48	1.86	0.32	6.23	5.61	010
11626	.....	A	Removal of skin lesion	4.30	3.20	2.28	0.51	8.01	7.09	010
11640	.....	A	Removal of skin lesion	1.53	1.77	1.02	0.15	3.45	2.70	010
11641	.....	A	Removal of skin lesion	2.44	2.15	1.51	0.18	4.77	4.13	010
11642	.....	A	Removal of skin lesion	2.93	2.24	1.74	0.23	5.40	4.90	010
11643	.....	A	Removal of skin lesion	3.50	2.57	2.05	0.28	6.35	5.83	010
11644	.....	A	Removal of skin lesion	4.55	3.17	2.61	0.33	8.05	7.49	010
11646	.....	A	Removal of skin lesion	5.95	4.21	3.41	0.60	10.76	9.96	010
11719	.....	R	Trim nail(s)	0.11	0.16	0.05	0.02	0.29	0.18	000
11720	.....	A	Debride nail, 1–5	0.32	0.23	0.21	0.03	0.58	0.56	000

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
11721	.....	A	Debride nail, 6 or more	0.54	0.33	0.31	0.05	0.92	0.90	000
11730	.....	A	Removal of nail plate	1.13	0.59	0.55	0.04	1.76	1.72	000
11731	.....	A	Removal of second nail plate	0.57	0.27	0.27	0.05	0.89	0.89	ZZZ
11732	.....	A	Remove additional nail plate	0.57	0.27	0.30	0.02	0.86	0.89	ZZZ
11740	.....	A	Drain blood from under nail	0.37	0.32	0.08	0.04	0.73	0.49	000
11750	.....	A	Removal of nail bed	1.86	1.37	1.16	0.19	3.42	3.21	010
11752	.....	A	Remove nail bed/finger tip	2.67	1.49	1.93	0.36	4.52	4.96	010
11755	.....	A	Biopsy, nail unit	1.31	0.82	0.96	0.12	2.25	2.39	000
11760	.....	A	Reconstruction of nail bed	1.58	1.10	1.24	0.09	2.77	2.91	010
11762	.....	A	Reconstruction of nail bed	2.89	1.54	2.05	0.24	4.67	5.18	010
11765	.....	A	Excision of nail fold, toe	0.69	0.53	0.55	0.05	1.27	1.29	010
11770	.....	A	Removal of pilonidal lesion	2.61	2.05	1.21	0.44	5.10	4.26	010
11771	.....	A	Removal of pilonidal lesion	5.74	4.26	3.31	0.92	10.92	9.97	090
11772	.....	A	Removal of pilonidal lesion	6.98	5.22	3.81	1.01	13.21	11.80	090
11900	.....	A	Injection into skin lesions	0.52	0.84	0.24	0.02	1.38	0.78	000
11901	.....	A	Added skin lesions injection	0.80	0.97	0.38	0.03	1.80	1.21	000
11920	.....	R	Correct skin color defects	1.61	2.43	0.94	0.23	4.27	2.78	000
11921	.....	R	Correct skin color defects	1.93	1.87	1.13	0.28	4.08	3.34	000
11922	.....	R	Correct skin color defects	0.49	2.10	0.52	0.07	2.66	1.08	ZZZ
11950	.....	R	Therapy for contour defects	0.84	1.01	0.33	0.11	1.96	1.28	000
11951	.....	R	Therapy for contour defects	1.19	1.65	0.77	0.11	2.95	2.07	000
11952	.....	R	Therapy for contour defects	1.69	2.47	0.99	0.11	4.27	2.79	000
11954	.....	R	Therapy for contour defects	1.85	2.20	0.82	0.11	4.16	2.78	000
11960	.....	A	Insert tissue expander(s)	9.08	NA	8.08	1.48	NA	18.64	090
11970	.....	A	Replace tissue expander	7.06	NA	4.67	1.61	NA	13.34	090
11971	.....	A	Remove tissue expander(s)	2.13	4.01	2.53	0.82	6.96	5.48	090
11975	.....	N	Insert contraceptive cap	+1.48	2.81	1.48	0.25	4.54	3.21	XXX
11976	.....	R	Removal of contraceptive cap	1.78	1.34	0.71	0.30	3.42	2.79	XXX
11977	.....	N	Removal/reinsert contra cap	+3.30	4.63	3.30	0.55	8.48	7.15	XXX
12001	.....	A	Repair superficial wound(s)	1.70	1.69	0.53	0.05	3.44	2.28	010
12002	.....	A	Repair superficial wound(s)	1.86	1.78	0.56	0.07	3.71	2.49	010
12004	.....	A	Repair superficial wound(s)	2.24	1.95	0.66	0.10	4.29	3.00	010
12005	.....	A	Repair superficial wound(s)	2.86	2.32	0.87	0.14	5.32	3.87	010
12006	.....	A	Repair superficial wound(s)	3.67	3.11	1.27	0.19	6.97	5.13	010
12007	.....	A	Repair superficial wound(s)	4.12	3.52	1.64	0.19	7.83	5.95	010
12011	.....	A	Repair superficial wound(s)	1.76	1.77	0.52	0.06	3.59	2.34	010
12013	.....	A	Repair superficial wound(s)	1.99	1.88	0.57	0.08	3.95	2.64	010
12014	.....	A	Repair superficial wound(s)	2.46	2.15	0.71	0.10	4.71	3.27	010
12015	.....	A	Repair superficial wound(s)	3.19	2.56	0.83	0.14	5.89	4.16	010
12016	.....	A	Repair superficial wound(s)	3.93	2.85	1.06	0.19	6.97	5.18	010
12017	.....	A	Repair superficial wound(s)	4.71	3.97	1.78	0.31	8.99	6.80	010
12018	.....	A	Repair superficial wound(s)	5.53	3.98	2.22	0.48	9.99	8.23	010
12020	.....	A	Closure of split wound	2.62	2.06	1.36	0.18	4.86	4.16	010
12021	.....	A	Closure of split wound	1.84	1.67	1.03	0.11	3.62	2.98	010
12031	.....	A	Layer closure of wound(s)	2.15	1.98	0.96	0.07	4.20	3.18	010
12032	.....	A	Layer closure of wound(s)	2.47	2.05	0.98	0.10	4.62	3.55	010
12034	.....	A	Layer closure of wound(s)	2.92	2.29	1.13	0.15	5.36	4.20	010
12035	.....	A	Layer closure of wound(s)	3.43	2.44	1.38	0.23	6.10	5.04	010
12036	.....	A	Layer closure of wound(s)	4.05	3.93	2.13	0.37	8.35	6.55	010
12037	.....	A	Layer closure of wound(s)	4.67	3.69	2.57	0.48	8.84	7.72	010
12041	.....	A	Layer closure of wound(s)	2.37	2.19	0.97	0.08	4.64	3.42	010
12042	.....	A	Layer closure of wound(s)	2.74	2.24	1.10	0.12	5.10	3.96	010
12044	.....	A	Layer closure of wound(s)	3.14	2.38	1.30	0.17	5.69	4.61	010
12045	.....	A	Layer closure of wound(s)	3.64	2.67	1.63	0.23	6.54	5.50	010
12046	.....	A	Layer closure of wound(s)	4.25	3.76	2.25	0.37	8.38	6.87	010
12047	.....	A	Layer closure of wound(s)	4.65	4.47	2.50	0.56	9.68	7.71	010
12051	.....	A	Layer closure of wound(s)	2.47	2.18	1.09	0.10	4.75	3.66	010
12052	.....	A	Layer closure of wound(s)	2.77	2.19	0.99	0.14	5.10	3.90	010
12053	.....	A	Layer closure of wound(s)	3.12	2.36	1.08	0.17	5.65	4.37	010
12054	.....	A	Layer closure of wound(s)	3.46	2.64	1.25	0.25	6.35	4.96	010
12055	.....	A	Layer closure of wound(s)	4.43	3.33	1.73	0.37	8.13	6.53	010
12056	.....	A	Layer closure of wound(s)	5.24	4.75	2.72	0.52	10.51	8.48	010
12057	.....	A	Layer closure of wound(s)	5.96	4.47	3.39	0.48	10.91	9.83	010
13100	.....	A	Repair of wound or lesion	3.12	2.60	1.76	0.13	5.85	5.01	010
13101	.....	A	Repair of wound or lesion	3.92	2.88	2.18	0.21	7.01	6.31	010
13120	.....	A	Repair of wound or lesion	3.30	2.73	1.64	0.17	6.20	5.11	010
13121	.....	A	Repair of wound or lesion	4.33	3.12	2.15	0.33	7.78	6.81	010
13131	.....	A	Repair of wound or lesion	3.79	3.02	2.11	0.23	7.04	6.13	010
13132	.....	A	Repair of wound or lesion	5.95	3.98	3.12	0.44	10.37	9.51	010
13150	.....	A	Repair of wound or lesion	3.81	3.86	2.37	0.23	7.90	6.41	010
13151	.....	A	Repair of wound or lesion	4.45	3.92	2.75	0.35	8.72	7.55	010
13152	.....	A	Repair of wound or lesion	6.33	4.71	3.73	0.68	11.72	10.74	010
13160	.....	A	Late closure of wound	10.48	NA	5.87	0.58	NA	16.93	090
13300	.....	A	Repair of wound or lesion	5.27	3.69	2.87	0.86	9.82	9.00	010

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
14000	.....	A	Skin tissue rearrangement	5.89	5.26	3.91	0.38	11.53	10.18	090
14001	.....	A	Skin tissue rearrangement	8.47	6.60	5.33	0.76	15.83	14.56	090
14020	.....	A	Skin tissue rearrangement	6.59	5.78	4.49	0.49	12.86	11.57	090
14021	.....	A	Skin tissue rearrangement	10.06	7.47	6.47	0.94	18.47	17.47	090
14040	.....	A	Skin tissue rearrangement	7.87	6.25	5.40	0.65	14.77	13.92	090
14041	.....	A	Skin tissue rearrangement	11.49	8.13	7.41	1.02	20.64	19.92	090
14060	.....	A	Skin tissue rearrangement	8.50	6.81	6.12	1.04	16.35	15.66	090
14061	.....	A	Skin tissue rearrangement	12.29	8.96	8.34	1.27	22.52	21.90	090
14300	.....	A	Skin tissue rearrangement	11.76	8.29	7.69	1.84	21.89	21.29	090
14350	.....	A	Skin tissue rearrangement	9.61	NA	5.87	1.05	NA	16.53	090
15000	.....	A	Skin graft procedure	1.95	1.26	1.04	0.53	3.74	3.52	ZZZ
15050	.....	A	Skin pinch graft procedure	4.30	3.65	3.16	0.30	8.25	7.76	090
15100	.....	A	Skin split graft procedure	9.05	5.64	6.52	0.89	15.58	16.46	090
15101	.....	A	Skin split graft procedure	1.72	1.16	0.83	0.33	3.21	2.88	ZZZ
15120	.....	A	Skin split graft procedure	9.83	6.78	6.22	0.94	17.55	16.99	090
15121	.....	A	Skin split graft procedure	2.67	1.58	1.40	0.53	4.78	4.60	ZZZ
15200	.....	A	Skin full graft procedure	8.03	7.04	5.00	0.69	15.76	13.72	090
15201	.....	A	Skin full graft procedure	1.32	0.84	0.69	0.50	2.66	2.51	ZZZ
15220	.....	A	Skin full graft procedure	7.87	6.91	5.28	0.85	15.63	14.00	090
15221	.....	A	Skin full graft procedure	1.19	0.77	0.66	0.50	2.46	2.35	ZZZ
15240	.....	A	Skin full graft procedure	9.04	7.11	6.10	1.03	17.18	16.17	090
15241	.....	A	Skin full graft procedure	1.86	1.25	1.04	0.58	3.69	3.48	ZZZ
15260	.....	A	Skin full graft procedure	10.06	7.34	6.92	0.99	18.39	17.97	090
15261	.....	A	Skin full graft procedure	2.23	1.40	1.27	0.60	4.23	4.10	ZZZ
15350	.....	A	Skin homograft procedure	4.36	6.41	5.19	0.42	11.19	9.97	090
15400	.....	A	Skin heterograft procedure	5.78	3.84	4.86	0.17	9.79	10.81	090
15570	.....	A	Form skin pedicle flap	9.21	5.97	6.57	2.08	17.26	17.86	090
15572	.....	A	Form skin pedicle flap	9.27	6.35	6.52	1.86	17.48	17.65	090
15574	.....	A	Form skin pedicle flap	9.88	6.89	6.44	1.66	18.43	17.98	090
15576	.....	A	Form skin pedicle flap	8.69	6.95	5.87	0.60	16.24	15.16	090
15580	.....	A	Attach skin pedicle graft	9.46	NA	6.38	1.30	NA	17.14	090
15600	.....	A	Skin graft procedure	1.91	3.27	1.71	0.88	6.06	4.50	090
15610	.....	A	Skin graft procedure	2.42	3.45	1.90	0.80	6.67	5.12	090
15620	.....	A	Skin graft procedure	2.94	3.88	2.55	0.86	7.68	6.35	090
15625	.....	A	Skin graft procedure	1.91	NA	2.88	0.78	NA	5.57	090
15630	.....	A	Skin graft procedure	3.27	4.16	2.83	0.90	8.33	7.00	090
15650	.....	A	Transfer skin pedicle flap	3.97	4.02	2.95	0.93	8.92	7.85	090
15732	.....	A	Muscle-skin graft, head/neck	17.84	NA	11.45	3.46	NA	32.75	090
15734	.....	A	Muscle-skin graft, trunk	17.79	NA	10.90	3.24	NA	31.93	090
15736	.....	A	Muscle-skin graft, arm	16.27	NA	10.22	3.02	NA	29.51	090
15738	.....	A	Muscle-skin graft, leg	17.92	NA	10.91	3.29	NA	32.12	090
15740	.....	A	Island pedicle flap graft	10.25	7.20	6.61	1.62	19.07	18.48	090
15750	.....	A	Neurovascular pedicle graft	11.41	NA	7.69	2.03	NA	21.13	090
15756	.....	A	Free muscle flap, microvasc	35.23	NA	21.75	5.33	NA	62.31	090
15757	.....	A	Free skin flap, microvasc	35.23	NA	21.75	5.33	NA	62.31	090
15758	.....	A	Free fascial flap, microvasc	35.10	NA	21.68	5.33	NA	62.11	090
15760	.....	A	Composite skin graft	8.74	7.06	7.41	1.11	16.91	17.26	090
15770	.....	A	Derma-fat-fascia graft	7.52	NA	5.51	0.95	NA	13.98	090
15775	.....	R	Hair transplant punch grafts	3.96	6.08	3.99	0.56	10.60	8.51	000
15776	.....	R	Hair transplant punch grafts	5.54	5.09	3.61	0.79	11.42	9.94	000
15780	.....	A	Abrasion treatment of skin	7.29	5.50	5.53	0.13	12.92	12.95	090
15781	.....	A	Abrasion treatment of skin	4.85	3.91	4.03	0.39	9.15	9.27	090
15782	.....	A	Abrasion treatment of skin	4.32	3.14	3.04	0.13	7.59	7.49	090
15783	.....	A	Abrasion treatment of skin	4.29	3.36	3.58	0.19	7.84	8.06	090
15786	.....	A	Abrasion treatment of lesion	2.03	1.40	1.30	0.06	3.49	3.39	010
15787	.....	A	Abrasion, added skin lesions	0.33	0.24	0.20	0.03	0.60	0.56	ZZZ
15788	.....	R	Chemical peel, face, epiderm	2.09	2.41	1.20	0.12	4.62	3.41	090
15789	.....	R	Chemical peel, face, dermal	4.92	4.08	3.54	0.12	9.12	8.58	090
15792	.....	R	Chemical peel, nonfacial	1.86	1.84	1.37	0.05	3.75	3.28	090
15793	.....	A	Chemical peel, nonfacial	3.74	NA	2.90	0.05	NA	6.69	090
15810	.....	A	Salabrasion	4.74	3.54	3.60	0.29	8.57	8.63	090
15811	.....	A	Salabrasion	5.39	4.95	4.14	0.73	11.07	10.26	090
15819	.....	A	Plastic surgery, neck	9.38	NA	5.81	0.87	NA	16.06	090
15820	.....	A	Revision of lower eyelid	5.15	7.71	6.23	0.64	13.50	12.02	090
15821	.....	A	Revision of lower eyelid	5.72	7.98	6.68	0.68	14.38	13.08	090
15822	.....	A	Revision of upper eyelid	4.45	7.04	5.85	0.56	12.05	10.86	090
15823	.....	A	Revision of upper eyelid	7.05	8.71	7.43	0.61	16.37	15.09	090
15831	.....	A	Excise excessive skin tissue	12.40	NA	8.16	2.01	NA	22.57	090
15832	.....	A	Excise excessive skin tissue	11.59	NA	8.09	1.33	NA	21.01	090
15833	.....	A	Excise excessive skin tissue	10.64	NA	7.38	1.12	NA	19.14	090
15834	.....	A	Excise excessive skin tissue	10.85	NA	5.52	1.22	NA	17.59	090
15835	.....	A	Excise excessive skin tissue	11.67	NA	6.43	1.22	NA	19.32	090
15836	.....	A	Excise excessive skin tissue	9.34	NA	7.09	1.10	NA	17.53	090
15837	.....	A	Excise excessive skin tissue	8.43	5.69	5.87	0.85	14.97	15.15	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
15838	.....	A	Excise excessive skin tissue	7.13	NA	5.97	0.73	NA	13.83	090
15839	.....	A	Excise excessive skin tissue	9.38	6.20	5.68	0.46	16.04	15.52	090
15840	.....	A	Graft for face nerve palsy	13.26	NA	9.23	2.28	NA	24.77	090
15841	.....	A	Graft for face nerve palsy	23.26	NA	13.57	2.76	NA	39.59	090
15842	.....	A	Graft for face nerve palsy	37.96	NA	23.74	2.68	NA	64.38	090
15845	.....	A	Skin and muscle repair, face	12.57	NA	8.35	2.54	NA	23.46	090
15850	.....	B	Removal of sutures	+0.78	2.24	0.82	0.04	3.06	1.64	XXX
15851	.....	A	Removal of sutures	0.86	1.17	0.37	0.03	2.06	1.26	000
15852	.....	A	Dressing change,not for burn	0.86	1.14	0.41	0.07	2.07	1.34	000
15860	.....	A	Test for blood flow in graft	1.95	1.26	0.99	0.25	3.46	3.19	000
15920	.....	A	Removal of tail bone ulcer	7.95	NA	4.64	0.63	NA	13.22	090
15922	.....	A	Removal of tail bone ulcer	9.90	NA	5.97	1.19	NA	17.06	090
15931	.....	A	Remove sacrum pressure sore	9.24	NA	4.66	0.55	NA	14.45	090
15933	.....	A	Remove sacrum pressure sore	10.85	NA	6.91	1.43	NA	19.19	090
15934	.....	A	Remove sacrum pressure sore	12.69	NA	7.56	1.50	NA	21.75	090
15935	.....	A	Remove sacrum pressure sore	14.57	NA	9.07	2.27	NA	25.91	090
15936	.....	A	Remove sacrum pressure sore	12.38	NA	7.87	2.05	NA	22.30	090
15937	.....	A	Remove sacrum pressure sore	14.21	NA	9.27	2.67	NA	26.15	090
15940	.....	A	Removal of pressure sore	9.34	NA	5.24	0.73	NA	15.31	090
15941	.....	A	Removal of pressure sore	11.43	NA	8.15	1.39	NA	20.97	090
15944	.....	A	Removal of pressure sore	11.46	NA	7.59	1.82	NA	20.87	090
15945	.....	A	Removal of pressure sore	12.69	NA	8.41	2.09	NA	23.19	090
15946	.....	A	Removal of pressure sore	21.57	NA	13.57	3.24	NA	38.38	090
15950	.....	A	Remove thigh pressure sore	7.54	NA	4.19	0.58	NA	12.31	090
15951	.....	A	Remove thigh pressure sore	10.72	NA	6.78	1.58	NA	19.08	090
15952	.....	A	Remove thigh pressure sore	11.39	NA	6.66	1.37	NA	19.42	090
15953	.....	A	Remove thigh pressure sore	12.63	NA	7.55	1.87	NA	22.05	090
15956	.....	A	Remove thigh pressure sore	15.52	NA	9.76	3.39	NA	28.67	090
15958	.....	A	Remove thigh pressure sore	15.48	NA	9.87	3.76	NA	29.11	090
16000	.....	A	Initial treatment of burn(s)	0.89	0.76	0.21	0.03	1.68	1.13	000
16010	.....	A	Treatment of burn(s)	0.87	0.82	0.34	0.03	1.72	1.24	000
16015	.....	A	Treatment of burn(s)	2.35	1.40	1.08	0.38	4.13	3.81	000
16020	.....	A	Treatment of burn(s)	0.80	0.80	0.23	0.03	1.63	1.06	000
16025	.....	A	Treatment of burn(s)	1.85	1.31	0.64	0.05	3.21	2.54	000
16030	.....	A	Treatment of burn(s)	2.08	1.93	0.99	0.08	4.09	3.15	000
16035	.....	A	Incision of burn scab	4.82	2.95	2.15	0.34	8.11	7.31	090
16040	.....	A	Burn wound excision	1.02	1.63	0.49	0.53	3.18	2.04	000
16041	.....	A	Burn wound excision	2.70	2.10	1.31	0.53	5.33	4.54	000
16042	.....	A	Burn wound excision	2.35	NA	1.17	0.53	NA	4.05	000
17000	.....	A	Destroy benign/premal lesion	0.60	0.86	0.60	0.03	1.49	1.23	010
17003	.....	A	Destroy 2–14 lesions	0.15	0.54	0.38	0.01	0.70	0.54	ZZZ
17004	.....	A	Destroy 15 & more lesions	2.79	2.05	1.74	0.20	5.04	4.73	010
17106	.....	A	Destruction of skin lesions	4.59	3.21	2.78	0.18	7.98	7.55	090
17107	.....	A	Destruction of skin lesions	9.16	5.82	5.26	0.39	15.37	14.81	090
17108	.....	A	Destruction of skin lesions	13.20	8.55	7.73	0.69	22.44	21.62	090
17110	.....	A	Destruct lesion, 1–14	0.65	1.18	0.71	0.03	1.86	1.39	010
17111	.....	A	Destruct lesion, 15 or more	0.92	1.30	0.83	0.05	2.27	1.80	010
17250	.....	A	Chemical cautery, tissue	0.50	0.45	0.20	0.04	0.99	0.74	000
17260	.....	A	Destruction of skin lesions	0.91	1.21	0.56	0.10	2.22	1.57	010
17261	.....	A	Destruction of skin lesions	1.17	1.30	0.70	0.12	2.59	1.99	010
17262	.....	A	Destruction of skin lesions	1.58	1.52	0.91	0.16	3.26	2.65	010
17263	.....	A	Destruction of skin lesions	1.79	1.64	1.00	0.21	3.64	3.00	010
17264	.....	A	Destruction of skin lesions	1.94	1.73	1.11	0.26	3.93	3.31	010
17266	.....	A	Destruction of skin lesions	2.34	1.98	1.21	0.49	4.81	4.04	010
17270	.....	A	Destruction of skin lesions	1.32	1.43	0.77	0.12	2.87	2.21	010
17271	.....	A	Destruction of skin lesions	1.49	1.47	0.87	0.16	3.12	2.52	010
17272	.....	A	Destruction of skin lesions	1.77	1.62	1.01	0.19	3.58	2.97	010
17273	.....	A	Destruction of skin lesions	2.05	1.79	1.14	0.25	4.09	3.44	010
17274	.....	A	Destruction of skin lesions	2.59	2.08	1.30	0.32	4.99	4.21	010
17276	.....	A	Destruction of skin lesions	3.20	2.09	1.76	0.51	5.80	5.47	010
17280	.....	A	Destruction of skin lesions	1.17	1.33	0.70	0.15	2.65	2.02	010
17281	.....	A	Destruction of skin lesions	1.72	1.60	1.01	0.18	3.50	2.91	010
17282	.....	A	Destruction of skin lesions	2.04	1.77	1.19	0.23	4.04	3.46	010
17283	.....	A	Destruction of skin lesions	2.64	2.11	1.51	0.28	5.03	4.43	010
17284	.....	A	Destruction of skin lesions	3.21	2.42	1.86	0.33	5.96	5.40	010
17286	.....	A	Destruction of skin lesions	4.44	2.80	2.58	0.60	7.84	7.62	010
17304	.....	A	Chemosurgery of skin lesion	7.60	5.90	4.28	0.31	13.81	12.19	000
17305	.....	A	2nd stage chemosurgery	2.85	2.23	1.66	0.17	5.25	4.68	000
17306	.....	A	3rd stage chemosurgery	2.85	2.23	1.67	0.11	5.19	4.63	000
17307	.....	A	Followup skin lesion therapy	2.85	2.23	1.69	0.12	5.20	4.66	000
17310	.....	A	Extensive skin chemosurgery	0.95	0.87	0.54	0.01	1.83	1.50	000
17340	.....	A	Cryotherapy of skin	0.76	1.54	0.86	0.02	2.32	1.64	010
17360	.....	A	Skin peel therapy	1.43	1.38	0.91	0.02	2.83	2.36	010
19000	.....	A	Drainage of breast lesion	0.84	1.16	0.28	0.07	2.07	1.19	000

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
19001	.....	A	Drain added breast lesion	0.42	0.86	0.14	0.05	1.33	0.61	ZZZ
19020	.....	A	Incision of breast lesion	3.57	4.63	2.48	0.28	8.48	6.33	090
19030	.....	A	Injection for breast x-ray	1.53	9.38	0.94	0.04	10.95	2.51	000
19100	.....	A	Biopsy of breast	1.27	2.45	0.79	0.13	3.85	2.19	000
19101	.....	A	Biopsy of breast	3.18	5.91	2.32	0.45	9.54	5.95	010
19110	.....	A	Nipple exploration	4.30	5.66	3.12	0.51	10.47	7.93	090
19112	.....	A	Excise breast duct fistula	3.67	4.79	2.33	0.35	8.81	6.35	090
19120	.....	A	Removal of breast lesion	5.56	3.29	4.14	0.60	9.45	10.30	090
19125	.....	A	Excision, breast lesion	6.06	3.61	4.75	0.60	10.27	11.41	090
19126	.....	A	Excision, add/-El breast lesion	2.93	NA	1.28	0.31	NA	4.52	ZZZ
19140	.....	A	Removal of breast tissue	5.14	6.25	2.91	0.91	12.30	8.96	090
19160	.....	A	Removal of breast tissue	5.99	NA	3.57	0.88	NA	10.44	090
19162	.....	A	Remove breast tissue, nodes	13.53	NA	7.01	1.96	NA	22.50	090
19180	.....	A	Removal of breast	8.80	NA	5.01	1.17	NA	14.98	090
19182	.....	A	Removal of breast	7.73	NA	4.40	1.27	NA	13.40	090
19200	.....	A	Removal of breast	15.49	NA	8.03	2.15	NA	25.67	090
19220	.....	A	Removal of breast	15.72	NA	8.48	2.38	NA	26.58	090
19240	.....	A	Removal of breast	16.00	NA	7.96	1.99	NA	25.95	090
19260	.....	A	Removal of chest wall lesion	15.44	NA	10.33	1.04	NA	26.81	090
19271	.....	A	Revision of chest wall	18.90	NA	12.42	2.77	NA	34.09	090
19272	.....	A	Extensive chest wall surgery	21.55	NA	14.21	2.56	NA	38.32	090
19290	.....	A	Place needle wire, breast	1.27	5.74	0.85	0.07	7.08	2.19	000
19291	.....	A	Place needle wire, breast	0.63	3.63	0.65	0.04	4.30	1.32	ZZZ
19316	.....	A	Suspension of breast	10.69	NA	7.01	2.43	NA	20.13	090
19318	.....	A	Reduction of large breast	15.62	NA	9.83	3.23	NA	28.68	090
19324	.....	A	Enlarge breast	5.85	NA	3.44	0.67	NA	9.96	090
19325	.....	A	Enlarge breast with implant	8.45	NA	5.87	1.13	NA	15.45	090
19328	.....	A	Removal of breast implant	5.68	NA	3.94	0.73	NA	10.35	090
19330	.....	A	Removal of implant material	7.59	NA	4.90	0.75	NA	13.24	090
19340	.....	A	Immediate breast prosthesis	6.33	NA	3.57	2.06	NA	11.96	ZZZ
19342	.....	A	Delayed breast prosthesis	11.20	NA	7.32	2.03	NA	20.55	090
19350	.....	A	Breast reconstruction	8.92	9.60	6.05	1.38	19.90	16.35	090
19355	.....	A	Correct inverted nipple(s)	7.57	10.44	5.12	1.00	19.01	13.69	090
19357	.....	A	Breast reconstruction	18.16	NA	12.25	2.37	NA	32.78	090
19361	.....	A	Breast reconstruction	19.26	NA	11.82	3.88	NA	34.96	090
19364	.....	A	Breast reconstruction	29.04	NA	17.48	3.58	NA	50.10	090
19366	.....	A	Breast reconstruction	21.28	NA	11.46	3.18	NA	35.92	090
19367	.....	A	Breast reconstruction	25.73	NA	15.21	3.88	NA	44.82	090
19368	.....	A	Breast reconstruction	32.42	NA	19.61	3.88	NA	55.91	090
19369	.....	A	Breast reconstruction	29.82	NA	17.91	3.88	NA	51.61	090
19370	.....	A	Surgery of breast capsule	8.05	NA	5.49	1.19	NA	14.73	090
19371	.....	A	Removal of breast capsule	9.35	NA	5.70	1.54	NA	16.59	090
19380	.....	A	Revise breast reconstruction	9.14	NA	6.24	1.57	NA	16.95	090
19396	.....	A	Design custom breast implant	2.17	2.97	1.26	0.31	5.45	3.74	000
20000	.....	A	Incision of abscess	2.12	1.59	1.03	0.08	3.79	3.23	010
20005	.....	A	Incision of deep abscess	3.42	2.27	1.92	0.28	5.97	5.62	010
20100	.....	A	Explore wound, neck	10.08	5.22	4.35	1.16	16.46	15.59	010
20101	.....	A	Explore wound, chest	3.22	1.73	1.49	0.37	5.32	5.08	010
20102	.....	A	Explore wound, abdomen	3.94	2.50	1.78	0.45	6.89	6.17	010
20103	.....	A	Explore wound, extremity	5.30	3.52	2.68	0.60	9.42	8.58	010
20150	.....	A	Excise epiphyseal bar	13.69	NA	19.46	2.03	NA	35.18	090
20200	.....	A	Muscle biopsy	1.46	1.28	0.64	0.18	2.92	2.28	000
20205	.....	A	Deep muscle biopsy	2.35	3.17	1.14	0.33	5.85	3.82	000
20206	.....	A	Needle biopsy, muscle	0.99	2.14	0.92	0.14	3.27	2.05	000
20220	.....	A	Bone biopsy, trocar/needle	1.27	1.67	1.36	0.09	3.03	2.72	000
20225	.....	A	Bone biopsy, trocar/needle	1.87	0.73	1.76	0.28	2.88	3.91	000
20240	.....	A	Bone biopsy, excisional	3.23	NA	2.69	0.18	NA	6.10	010
20245	.....	A	Bone biopsy, excisional	3.95	NA	3.60	0.44	NA	7.99	010
20250	.....	A	Open bone biopsy	5.03	NA	3.61	0.76	NA	9.40	010
20251	.....	A	Open bone biopsy	5.56	NA	4.37	0.92	NA	10.85	010
20500	.....	A	Injection of sinus tract	1.23	2.80	2.12	0.04	4.07	3.39	010
20501	.....	A	Inject sinus tract for x-ray	0.76	7.35	0.42	0.02	8.13	1.20	000
20520	.....	A	Removal of foreign body	1.85	3.00	1.93	0.08	4.93	3.86	010
20525	.....	A	Removal of foreign body	3.50	3.75	3.05	0.33	7.58	6.88	010
20550	.....	A	Inj tendon/ligament/cyst	0.86	2.07	0.29	0.04	2.97	1.19	000
20600	.....	A	Drain/inject joint/bursa	0.66	1.25	0.39	0.05	1.96	1.10	000
20605	.....	A	Drain/inject joint/bursa	0.68	1.76	0.38	0.05	2.49	1.11	000
20610	.....	A	Drain/inject joint/bursa	0.79	1.38	0.45	0.05	2.22	1.29	000
20615	.....	A	Treatment of bone cyst	2.28	2.75	1.84	0.06	5.09	4.18	010
20650	.....	A	Insert and remove bone pin	2.23	2.45	2.05	0.14	4.82	4.42	010
20660	.....	A	Apply,remove fixation device	2.51	NA	1.40	0.21	NA	4.12	000
20661	.....	A	Application of head brace	4.89	NA	5.01	0.65	NA	10.55	090
20662	.....	A	Application of pelvis brace	6.07	NA	4.67	1.03	NA	11.77	090
20663	.....	A	Application of thigh brace	5.43	NA	4.52	0.76	NA	10.71	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
20664	.....	A	Halo brace application	8.06	NA	6.77	0.65	NA	15.48	090
20665	.....	A	Removal of fixation device	1.31	1.31	1.09	0.07	2.69	2.47	010
20670	.....	A	Removal of support implant	1.74	3.72	2.50	0.11	5.57	4.35	010
20680	.....	A	Removal of support implant	3.35	3.33	6.39	0.51	7.19	10.25	090
20690	.....	A	Apply bone fixation device	3.52	NA	2.31	0.58	NA	6.41	ZZZ
20692	.....	A	Apply bone fixation device	6.41	NA	3.92	0.89	NA	11.22	ZZZ
20693	.....	A	Adjust bone fixation device	5.86	NA	8.69	0.42	NA	14.97	090
20694	.....	A	Remove bone fixation device	4.16	6.02	4.74	0.41	10.59	9.31	090
20802	.....	A	Replantation, arm, complete	41.15	NA	29.93	6.17	NA	77.25	090
20805	.....	A	Replant forearm, complete	50.00	NA	34.58	7.56	NA	92.14	090
20808	.....	A	Replantation, hand, complete	61.65	NA	46.78	9.40	NA	117.83	090
20816	.....	A	Replantation digit, complete	30.94	NA	34.06	4.63	NA	69.63	090
20822	.....	A	Replantation digit, complete	25.59	NA	27.59	3.83	NA	57.01	090
20824	.....	A	Replantation thumb, complete	30.94	NA	25.23	4.63	NA	60.80	090
20827	.....	A	Replantation thumb, complete	26.41	NA	29.76	3.94	NA	60.11	090
20838	.....	A	Replantation, foot, complete	41.41	NA	28.93	6.17	NA	76.51	090
20900	.....	A	Removal of bone for graft	5.58	4.53	5.00	0.45	10.56	11.03	090
20902	.....	A	Removal of bone for graft	7.55	NA	7.14	0.80	NA	15.49	090
20910	.....	A	Remove cartilage for graft	5.34	5.32	4.76	0.09	10.75	10.19	090
20912	.....	A	Remove cartilage for graft	6.35	NA	4.97	0.64	NA	11.96	090
20920	.....	A	Removal of fascia for graft	5.31	NA	4.72	0.50	NA	10.53	090
20922	.....	A	Removal of fascia for graft	6.61	5.86	5.18	0.71	13.18	12.50	090
20924	.....	A	Removal of tendon for graft	6.48	NA	5.62	0.85	NA	12.95	090
20926	.....	A	Removal of tissue for graft	5.53	NA	4.71	0.39	NA	10.63	090
20931	.....	A	Spinal bone allograft	1.81	NA	1.24	0.28	NA	3.33	ZZZ
20937	.....	A	Spinal bone autograft	2.79	NA	1.84	0.44	NA	5.07	ZZZ
20938	.....	A	Spinal bone autograft	3.02	NA	1.93	0.47	NA	5.42	ZZZ
20950	.....	A	Record fluid pressure,muscle	1.26	NA	1.54	0.17	NA	2.97	000
20955	.....	A	Fibula bone graft, microvasc	39.21	NA	26.94	5.87	NA	72.02	090
20956	.....	A	Iliac bone graft, microvasc	39.27	NA	49.63	5.26	NA	94.16	090
20957	.....	A	Mt bone graft, microvasc	40.65	NA	51.01	5.45	NA	97.11	090
20962	.....	A	Other bone graft, microvasc	39.27	NA	25.47	5.26	NA	70.00	090
20969	.....	A	Bone/skin graft, microvasc	43.92	NA	28.73	6.57	NA	79.22	090
20970	.....	A	Bone/skin graft, iliac crest	43.06	NA	28.02	6.44	NA	77.52	090
20972	.....	A	Bone-skin graft, metatarsal	42.99	NA	19.72	6.49	NA	69.20	090
20973	.....	A	Bone-skin graft, great toe	45.76	NA	28.05	6.91	NA	80.72	090
20974	.....	A	Electrical bone stimulation	0.62	0.32	0.35	0.53	1.47	1.50	000
20975	.....	A	Electrical bone stimulation	2.60	NA	1.48	0.56	NA	4.64	ZZZ
21010	.....	A	Incision of jaw joint	10.14	NA	7.03	0.93	NA	18.10	090
21015	.....	A	Resection of facial tumor	5.29	NA	5.98	1.13	NA	12.40	090
21025	.....	A	Excision of bone, lower jaw	10.06	6.82	6.53	0.38	17.26	16.97	090
21026	.....	A	Excision of facial bone(s)	4.85	4.64	4.23	0.28	9.77	9.36	090
21029	.....	A	Contour of face bone lesion	7.71	5.81	5.77	0.78	14.30	14.26	090
21030	.....	A	Removal of face bone lesion	6.46	5.05	4.42	0.29	11.80	11.17	090
21031	.....	A	Remove exostosis, mandible	3.24	3.24	2.14	0.32	6.80	5.70	090
21032	.....	A	Remove exostosis, maxilla	3.24	3.21	2.19	0.35	6.80	5.78	090
21034	.....	A	Removal of face bone lesion	16.17	9.87	10.61	0.89	26.93	27.67	090
21040	.....	A	Removal of jaw bone lesion	2.11	2.89	1.77	0.24	5.24	4.12	090
21041	.....	A	Removal of jaw bone lesion	6.71	5.24	4.24	0.50	12.45	11.45	090
21044	.....	A	Removal of jaw bone lesion	11.86	NA	7.91	1.11	NA	20.88	090
21045	.....	A	Extensive jaw surgery	16.17	NA	10.49	1.58	NA	28.24	090
21050	.....	A	Removal of jaw joint	10.77	NA	10.16	1.08	NA	22.01	090
21060	.....	A	Remove jaw joint cartilage	10.23	NA	8.88	1.04	NA	20.15	090
21070	.....	A	Remove coronoid process	8.20	NA	6.32	0.82	NA	15.34	090
21076	.....	A	Prepare face/oral prosthesis	13.42	6.70	5.60	1.35	21.47	20.37	010
21077	.....	A	Prepare face/oral prosthesis	33.75	14.90	17.42	3.39	52.04	54.56	090
21079	.....	A	Prepare face/oral prosthesis	22.34	10.55	9.52	2.25	35.14	34.11	090
21080	.....	A	Prepare face/oral prosthesis	25.10	11.63	10.47	2.52	39.25	38.09	090
21081	.....	A	Prepare face/oral prosthesis	22.88	10.89	9.62	2.30	36.07	34.80	090
21082	.....	A	Prepare face/oral prosthesis	20.87	9.85	8.69	2.10	32.82	31.66	090
21083	.....	A	Prepare face/oral prosthesis	19.30	9.20	8.08	1.94	30.44	29.32	090
21084	.....	A	Prepare face/oral prosthesis	22.51	12.25	12.54	2.28	37.04	37.33	090
21085	.....	A	Prepare face/oral prosthesis	9.00	5.01	3.87	0.90	14.91	13.77	010
21086	.....	A	Prepare face/oral prosthesis	24.92	12.00	13.68	2.51	39.43	41.11	090
21087	.....	A	Prepare face/oral prosthesis	24.92	11.66	11.30	2.51	39.09	38.73	090
21100	.....	A	Maxillofacial fixation	4.22	4.14	3.69	0.11	8.47	8.02	090
21110	.....	A	Interdental fixation	5.21	4.75	3.82	0.46	10.42	9.49	090
21116	.....	A	Injection, jaw joint x-ray	0.81	5.51	0.27	0.06	6.38	1.14	000
21120	.....	A	Reconstruction of chin	4.93	5.71	5.13	0.42	11.06	10.48	090
21121	.....	A	Reconstruction of chin	7.64	6.30	6.30	0.66	14.60	14.60	090
21122	.....	A	Reconstruction of chin	8.52	NA	7.00	0.73	NA	16.25	090
21123	.....	A	Reconstruction of chin	11.16	NA	20.06	0.95	NA	32.17	090
21125	.....	A	Augmentation lower jaw bone	10.62	7.69	7.67	0.54	18.85	18.83	090
21127	.....	A	Augmentation lower jaw bone	11.12	8.30	7.47	0.92	20.34	19.51	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
21137	.....	A	Reduction of forehead	9.82	NA	7.29	0.83	NA	17.94	090
21138	.....	A	Reduction of forehead	12.19	NA	7.64	1.04	NA	20.87	090
21139	.....	A	Reduction of forehead	14.61	NA	11.04	1.25	NA	26.90	090
21141	.....	A	Reconstruct midface, lefort	18.10	NA	10.89	1.68	NA	30.67	090
21142	.....	A	Reconstruct midface, lefort	18.81	NA	13.27	1.74	NA	33.82	090
21143	.....	A	Reconstruct midface, lefort	19.58	NA	11.67	1.81	NA	33.06	090
21145	.....	A	Reconstruct midface, lefort	19.94	NA	11.71	1.68	NA	33.33	090
21146	.....	A	Reconstruct midface, lefort	20.71	NA	12.56	1.74	NA	35.01	090
21147	.....	A	Reconstruct midface, lefort	21.77	NA	13.16	1.81	NA	36.74	090
21150	.....	A	Reconstruct midface, lefort	25.24	NA	15.59	2.17	NA	43.00	090
21151	.....	A	Reconstruct midface, lefort	28.30	NA	15.30	2.42	NA	46.02	090
21154	.....	A	Reconstruct midface, lefort	30.52	NA	22.04	2.59	NA	55.15	090
21155	.....	A	Reconstruct midface, lefort	34.45	NA	51.03	2.94	NA	88.42	090
21159	.....	A	Reconstruct midface, lefort	42.38	NA	60.58	3.63	NA	106.59	090
21160	.....	A	Reconstruct midface, lefort	46.44	NA	64.64	3.98	NA	115.06	090
21172	.....	A	Reconstruct orbit/forehead	27.80	NA	21.24	2.37	NA	51.41	090
21175	.....	A	Reconstruct orbit/forehead	33.17	NA	24.31	2.85	NA	60.33	090
21179	.....	A	Reconstruct entire forehead	22.25	NA	18.66	1.90	NA	42.81	090
21180	.....	A	Reconstruct entire forehead	25.19	NA	24.32	2.17	NA	51.68	090
21181	.....	A	Contour cranial bone lesion	9.90	NA	8.05	0.83	NA	18.78	090
21182	.....	A	Reconstruct cranial bone	32.19	NA	24.10	2.77	NA	59.06	090
21183	.....	A	Reconstruct cranial bone	35.31	NA	25.88	3.03	NA	64.22	090
21184	.....	A	Reconstruct cranial bone	38.24	NA	29.40	3.28	NA	70.92	090
21188	.....	A	Reconstruction of midface	22.46	NA	18.26	1.90	NA	42.62	090
21193	.....	A	Reconstruct lower jaw bone	17.15	NA	10.91	1.44	NA	29.50	090
21194	.....	A	Reconstruct lower jaw bone	19.84	NA	12.92	1.67	NA	34.43	090
21195	.....	A	Reconstruct lower jaw bone	17.24	NA	11.08	1.44	NA	29.76	090
21196	.....	A	Reconstruct lower jaw bone	18.91	NA	13.53	1.58	NA	34.02	090
21198	.....	A	Reconstruct lower jaw bone	14.16	NA	10.93	1.74	NA	26.83	090
21206	.....	A	Reconstruct upper jaw bone	14.10	NA	10.52	1.19	NA	25.81	090
21208	.....	A	Augmentation of facial bones	10.23	7.88	8.26	1.07	19.18	19.56	090
21209	.....	A	Reduction of facial bones	6.72	6.05	6.22	0.76	13.53	13.70	090
21210	.....	A	Face bone graft	10.23	7.72	7.87	1.29	19.24	19.39	090
21215	.....	A	Lower jaw bone graft	10.77	7.83	7.13	1.42	20.02	19.32	090
21230	.....	A	Rib cartilage graft	10.77	NA	9.34	1.69	NA	21.80	090
21235	.....	A	Ear cartilage graft	6.72	8.15	7.42	1.09	15.96	15.23	090
21240	.....	A	Reconstruction of jaw joint	14.05	NA	10.46	2.09	NA	26.60	090
21242	.....	A	Reconstruction of jaw joint	12.95	NA	10.05	2.25	NA	25.25	090
21243	.....	A	Reconstruction of jaw joint	20.79	NA	13.24	1.68	NA	35.71	090
21244	.....	A	Reconstruction of lower jaw	11.86	NA	9.33	1.93	NA	23.12	090
21245	.....	A	Reconstruction of jaw	11.86	8.63	9.93	1.31	21.80	23.10	090
21246	.....	A	Reconstruction of jaw	12.47	8.83	9.24	1.04	22.34	22.75	090
21247	.....	A	Reconstruct lower jaw bone	22.63	NA	14.51	2.27	NA	39.41	090
21248	.....	A	Reconstruction of jaw	11.48	7.91	7.71	1.75	21.14	20.94	090
21249	.....	A	Reconstruction of jaw	17.52	10.43	10.44	3.29	31.24	31.25	090
21255	.....	A	Reconstruct lower jaw bone	16.72	NA	11.63	1.68	NA	30.03	090
21256	.....	A	Reconstruction of orbit	16.19	NA	14.89	1.63	NA	32.71	090
21260	.....	A	Revise eye sockets	16.52	NA	14.04	1.66	NA	32.22	090
21261	.....	A	Revise eye sockets	31.49	NA	17.06	1.65	NA	50.20	090
21263	.....	A	Revise eye sockets	28.42	NA	45.24	2.86	NA	76.52	090
21267	.....	A	Revise eye sockets	18.90	NA	20.67	2.13	NA	41.70	090
21268	.....	A	Revise eye sockets	24.48	NA	18.34	3.13	NA	45.95	090
21270	.....	A	Augmentation cheek bone	10.23	5.40	9.69	1.41	17.04	21.33	090
21275	.....	A	Revision orbitofacial bones	11.24	NA	13.42	1.26	NA	25.92	090
21280	.....	A	Revision of eyelid	6.03	NA	8.21	0.61	NA	14.85	090
21282	.....	A	Revision of eyelid	3.49	NA	6.72	0.79	NA	11.00	090
21295	.....	A	Revision of jaw muscle/bone	1.53	NA	3.72	0.13	NA	5.38	090
21296	.....	A	Revision of jaw muscle/bone	4.25	NA	5.02	0.22	NA	9.49	090
21300	.....	A	Treatment of skull fracture	0.72	3.32	0.21	0.11	4.15	1.04	000
21310	.....	A	Treatment of nose fracture	0.58	2.47	0.11	0.09	3.14	0.78	000
21315	.....	A	Treatment of nose fracture	1.51	2.93	0.89	0.21	4.65	2.61	010
21320	.....	A	Treatment of nose fracture	1.85	3.06	1.65	0.34	5.25	3.84	010
21325	.....	A	Repair of nose fracture	3.77	NA	2.81	0.52	NA	7.10	090
21330	.....	A	Repair of nose fracture	5.38	NA	5.97	0.86	NA	12.21	090
21335	.....	A	Repair of nose fracture	8.61	NA	8.02	1.56	NA	18.19	090
21336	.....	A	Repair nasal septal fracture	5.72	NA	5.91	0.52	NA	12.15	090
21337	.....	A	Repair nasal septal fracture	2.70	4.38	2.39	0.38	7.46	5.47	090
21338	.....	A	Repair nasoethmoid fracture	6.46	NA	6.39	0.66	NA	13.51	090
21339	.....	A	Repair nasoethmoid fracture	8.09	NA	7.31	0.70	NA	16.10	090
21340	.....	A	Repair of nose fracture	10.77	NA	9.73	1.04	NA	21.54	090
21343	.....	A	Repair of sinus fracture	12.95	NA	9.61	1.08	NA	23.64	090
21344	.....	A	Repair of sinus fracture	19.72	NA	14.46	1.08	NA	35.26	090
21345	.....	A	Repair of nose/jaw fracture	8.16	7.04	7.45	0.81	16.01	16.42	090
21346	.....	A	Repair of nose/jaw fracture	10.61	NA	9.74	1.04	NA	21.39	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
21347	.....	A	Repair of nose/jaw fracture	12.69	NA	9.53	1.36	NA	23.58	090
21348	.....	A	Repair of nose/jaw fracture	16.69	NA	12.22	2.22	NA	31.13	090
21355	.....	A	Repair cheek bone fracture	3.77	3.40	1.74	0.17	7.34	5.68	010
21356	.....	A	Repair cheek bone fracture	4.15	NA	4.79	0.89	NA	9.83	010
21360	.....	A	Repair cheek bone fracture	6.46	NA	6.84	0.89	NA	14.19	090
21365	.....	A	Repair cheek bone fracture	14.95	NA	11.74	1.63	NA	28.32	090
21366	.....	A	Repair cheek bone fracture	17.77	NA	9.32	2.36	NA	29.45	090
21385	.....	A	Repair eye socket fracture	9.16	NA	7.61	1.13	NA	17.90	090
21386	.....	A	Repair eye socket fracture	9.16	NA	8.63	1.25	NA	19.04	090
21387	.....	A	Repair eye socket fracture	9.70	NA	9.10	0.96	NA	19.76	090
21390	.....	A	Repair eye socket fracture	10.13	NA	10.45	1.37	NA	21.95	090
21395	.....	A	Repair eye socket fracture	12.68	NA	10.66	1.37	NA	24.71	090
21400	.....	A	Treat eye socket fracture	1.40	3.31	0.65	0.17	4.88	2.22	090
21401	.....	A	Repair eye socket fracture	3.26	3.98	2.31	0.32	7.56	5.89	090
21406	.....	A	Repair eye socket fracture	7.01	NA	7.24	0.74	NA	14.99	090
21407	.....	A	Repair eye socket fracture	8.61	NA	8.85	0.78	NA	18.24	090
21408	.....	A	Repair eye socket fracture	12.38	NA	9.57	0.99	NA	22.94	090
21421	.....	A	Treat mouth roof fracture	5.14	6.15	5.17	0.62	11.91	10.93	090
21422	.....	A	Repair mouth roof fracture	8.32	NA	7.33	1.19	NA	16.84	090
21423	.....	A	Repair mouth roof fracture	10.40	NA	8.31	1.19	NA	19.90	090
21431	.....	A	Treat craniofacial fracture	7.05	NA	5.95	0.71	NA	13.71	090
21432	.....	A	Repair craniofacial fracture	8.61	NA	7.78	0.84	NA	17.23	090
21433	.....	A	Repair craniofacial fracture	25.35	NA	17.90	2.10	NA	45.35	090
21435	.....	A	Repair craniofacial fracture	17.25	NA	13.29	1.88	NA	32.42	090
21436	.....	A	Repair craniofacial fracture	28.04	NA	17.06	2.08	NA	47.18	090
21440	.....	A	Repair dental ridge fracture	2.70	4.56	3.56	0.28	7.54	6.54	090
21445	.....	A	Repair dental ridge fracture	5.38	5.56	5.29	0.56	11.50	11.23	090
21450	.....	A	Treat lower jaw fracture	2.97	4.24	3.45	0.26	7.47	6.68	090
21451	.....	A	Treat lower jaw fracture	4.87	5.43	4.60	0.74	11.04	10.21	090
21452	.....	A	Treat lower jaw fracture	1.98	6.58	3.89	0.17	8.73	6.04	090
21453	.....	A	Treat lower jaw fracture	5.54	5.95	5.49	0.55	12.04	11.58	090
21454	.....	A	Treat lower jaw fracture	6.46	NA	5.76	1.42	NA	13.64	090
21461	.....	A	Repair lower jaw fracture	8.09	8.12	7.14	1.30	17.51	16.53	090
21462	.....	A	Repair lower jaw fracture	9.79	8.46	7.77	1.34	19.59	18.90	090
21465	.....	A	Repair lower jaw fracture	11.91	NA	8.02	0.99	NA	20.92	090
21470	.....	A	Repair lower jaw fracture	15.34	NA	10.11	1.74	NA	27.19	090
21480	.....	A	Reset dislocated jaw	0.61	1.75	0.16	0.09	2.45	0.86	000
21485	.....	A	Reset dislocated jaw	3.99	3.72	2.48	0.20	7.91	6.67	090
21490	.....	A	Repair dislocated jaw	11.86	NA	7.48	0.52	NA	19.86	090
21493	.....	A	Treat hyoid bone fracture	1.27	0.59	3.15	0.13	1.99	4.55	090
21494	.....	A	Repair hyoid bone fracture	6.28	2.63	3.70	0.63	9.54	10.61	090
21495	.....	A	Repair hyoid bone fracture	5.69	NA	5.95	0.51	NA	12.15	090
21497	.....	A	Interdental wiring	3.86	4.11	3.29	0.38	8.35	7.53	090
21501	.....	A	Drain neck/chest lesion	3.81	3.16	2.67	0.26	7.23	6.74	090
21502	.....	A	Drain chest lesion	7.12	NA	9.17	0.75	NA	17.04	090
21510	.....	A	Drainage of bone lesion	5.74	NA	7.85	0.50	NA	14.09	090
21550	.....	A	Biopsy of neck/chest	2.06	1.72	1.17	0.12	3.90	3.35	010
21555	.....	A	Remove lesion neck/chest	4.35	3.34	2.37	0.25	7.94	6.97	090
21556	.....	A	Remove lesion neck/chest	5.57	NA	3.17	0.64	NA	9.38	090
21557	.....	A	Remove tumor, neck or chest	8.88	NA	8.79	1.41	NA	19.08	090
21600	.....	A	Partial removal of rib	6.89	NA	8.31	0.88	NA	16.08	090
21610	.....	A	Partial removal of rib	14.61	NA	9.89	0.76	NA	25.26	090
21615	.....	A	Removal of rib	9.87	NA	8.38	1.96	NA	20.21	090
21616	.....	A	Removal of rib and nerves	12.04	NA	9.33	1.50	NA	22.87	090
21620	.....	A	Partial removal of sternum	6.79	NA	7.60	1.23	NA	15.62	090
21627	.....	A	Sternal debridement	6.81	NA	12.71	0.90	NA	20.42	090
21630	.....	A	Extensive sternum surgery	17.38	NA	15.34	2.40	NA	35.12	090
21632	.....	A	Extensive sternum surgery	18.14	NA	13.05	2.22	NA	33.41	090
21700	.....	A	Revision of neck muscle	6.19	5.11	4.88	0.50	11.80	11.57	090
21705	.....	A	Revision of neck muscle/rib	9.60	NA	10.23	0.96	NA	20.79	090
21720	.....	A	Revision of neck muscle	5.68	6.36	4.90	0.52	12.56	11.10	090
21725	.....	A	Revision of neck muscle	6.99	NA	6.16	0.74	NA	13.89	090
21740	.....	A	Reconstruction of sternum	16.50	NA	13.90	1.64	NA	32.04	090
21750	.....	A	Repair of sternum separation	10.77	NA	9.53	1.43	NA	21.73	090
21800	.....	A	Treatment of rib fracture	0.96	1.33	0.63	0.07	2.36	1.66	090
21805	.....	A	Treatment of rib fracture	2.75	NA	3.08	0.17	NA	6.00	090
21810	.....	A	Treatment of rib fracture(s)	6.86	NA	8.65	0.61	NA	16.12	090
21820	.....	A	Treat sternum fracture	1.28	1.74	0.99	0.17	3.19	2.44	090
21825	.....	A	Repair sternum fracture	7.41	NA	7.42	1.12	NA	15.95	090
21920	.....	A	Biopsy soft tissue of back	2.06	1.75	0.85	0.11	3.92	3.02	010
21925	.....	A	Biopsy soft tissue of back	4.49	7.49	3.55	0.32	12.30	8.36	090
21930	.....	A	Remove lesion, back or flank	5.00	3.64	2.52	0.49	9.13	8.01	090
21935	.....	A	Remove tumor of back	17.96	NA	11.23	1.30	NA	30.49	090
22100	.....	A	Remove part of neck vertebra	9.73	NA	7.68	1.09	NA	18.50	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
22101	.....	A	Remove part, thorax vertebra	9.81	NA	7.77	1.38	NA	18.96	090
22102	.....	A	Remove part, lumbar vertebra	9.81	NA	7.35	0.67	NA	17.83	090
22103	.....	A	Remove extra spine segment	2.34	NA	1.45	0.37	NA	4.16	ZZZ
22110	.....	A	Remove part of neck vertebra	12.74	NA	9.72	1.64	NA	24.10	090
22112	.....	A	Remove part, thorax vertebra	12.81	NA	9.70	1.63	NA	24.14	090
22114	.....	A	Remove part, lumbar vertebra	12.81	NA	9.69	1.17	NA	23.67	090
22116	.....	A	Remove extra spine segment	2.32	NA	1.42	0.36	NA	4.10	ZZZ
22210	.....	A	Revision of neck spine	23.82	NA	16.43	2.43	NA	42.68	090
22212	.....	A	Revision of thorax spine	19.42	NA	14.76	2.83	NA	37.01	090
22214	.....	A	Revision of lumbar spine	19.45	NA	13.95	2.68	NA	36.08	090
22216	.....	A	Revise, extra spine segment	6.04	NA	3.51	0.89	NA	10.44	ZZZ
22220	.....	A	Revision of neck spine	21.37	NA	14.66	2.63	NA	38.66	090
22222	.....	A	Revision of thorax spine	21.52	NA	13.03	1.58	NA	36.13	090
22224	.....	A	Revision of lumbar spine	21.52	NA	14.52	2.66	NA	38.70	090
22226	.....	A	Revise, extra spine segment	6.04	NA	3.43	0.89	NA	10.36	ZZZ
22305	.....	A	Treat spine process fracture	2.05	2.22	1.58	0.37	4.64	4.00	090
22310	.....	A	Treat spine fracture	2.61	3.25	2.82	0.69	6.55	6.12	090
22315	.....	A	Treat spine fracture	8.84	NA	7.92	0.86	NA	17.62	090
22325	.....	A	Repair of spine fracture	18.30	NA	11.68	1.34	NA	31.32	090
22326	.....	A	Repair neck spine fracture	19.59	NA	14.02	2.74	NA	36.35	090
22327	.....	A	Repair thorax spine fracture	19.20	NA	13.47	2.35	NA	35.02	090
22328	.....	A	Repair each add spine fx	4.61	NA	2.57	0.72	NA	7.90	ZZZ
22505	.....	A	Manipulation of spine	1.87	2.43	1.66	0.17	4.47	3.70	010
22548	.....	A	Neck spine fusion	25.82	NA	17.17	3.82	NA	46.81	090
22554	.....	A	Neck spine fusion	18.62	NA	12.68	3.52	NA	34.82	090
22556	.....	A	Thorax spine fusion	23.46	NA	16.24	3.58	NA	43.28	090
22558	.....	A	Lumbar spine fusion	22.28	NA	15.16	3.38	NA	40.82	090
22585	.....	A	Additional spinal fusion	5.53	NA	3.18	0.93	NA	9.64	ZZZ
22590	.....	A	Spine & skull spinal fusion	20.51	NA	14.43	3.44	NA	38.38	090
22595	.....	A	Neck spinal fusion	19.39	NA	13.40	3.87	NA	36.66	090
22600	.....	A	Neck spine fusion	16.14	NA	11.81	3.32	NA	31.27	090
22610	.....	A	Thorax spine fusion	16.02	NA	12.11	2.75	NA	30.88	090
22612	.....	A	Lumbar spine fusion	21.00	NA	14.94	3.33	NA	39.27	090
22614	.....	A	Spine fusion, extra segment	6.44	NA	3.78	0.92	NA	11.14	ZZZ
22630	.....	A	Lumbar spine fusion	20.84	NA	14.85	3.15	NA	38.84	090
22632	.....	A	Spine fusion, extra segment	5.23	NA	3.01	0.82	NA	9.06	ZZZ
22800	.....	A	Fusion of spine	18.25	NA	13.50	3.58	NA	35.33	090
22802	.....	A	Fusion of spine	30.88	NA	21.23	4.61	NA	56.72	090
22804	.....	A	Fusion of spine	36.27	NA	24.20	4.61	NA	65.08	090
22808	.....	A	Fusion of spine	26.27	NA	18.13	3.15	NA	47.55	090
22810	.....	A	Fusion of spine	30.27	NA	19.97	3.15	NA	53.39	090
22812	.....	A	Fusion of spine	32.70	NA	21.49	4.24	NA	58.43	090
22818	.....	A	Kyphectomy, 1–2 segments	31.83	NA	19.42	4.85	NA	56.10	090
22819	.....	A	Kyphectomy, 3 & more segment	36.44	NA	21.75	4.85	NA	63.04	090
22830	.....	A	Exploration of spinal fusion	10.85	NA	8.96	2.18	NA	21.99	090
22840	.....	A	Insert spine fixation device	12.54	NA	7.94	0.98	NA	21.46	ZZZ
22842	.....	A	Insert spine fixation device	12.58	NA	7.54	1.12	NA	21.24	ZZZ
22843	.....	A	Insert spine fixation device	13.46	NA	8.67	1.40	NA	23.53	ZZZ
22844	.....	A	Insert spine fixation device	16.44	NA	10.38	1.71	NA	28.53	ZZZ
22845	.....	A	Insert spine fixation device	11.96	NA	7.56	0.93	NA	20.45	ZZZ
22846	.....	A	Insert spine fixation device	12.42	NA	7.87	1.29	NA	21.58	ZZZ
22847	.....	A	Insert spine fixation device	13.80	NA	8.62	1.44	NA	23.86	ZZZ
22848	.....	A	Insert pelvic fixation device	6.00	NA	4.63	0.94	NA	11.57	ZZZ
22849	.....	A	Reinsert spinal fixation	18.51	NA	13.16	1.97	NA	33.64	090
22850	.....	A	Remove spine fixation device	9.52	NA	7.79	1.50	NA	18.81	090
22851	.....	A	Apply spine prosth device	6.71	NA	4.70	1.05	NA	12.46	ZZZ
22852	.....	A	Remove spine fixation device	9.01	NA	7.52	1.57	NA	18.10	090
22855	.....	A	Remove spine fixation device	15.13	NA	10.74	1.25	NA	27.12	090
22900	.....	A	Remove abdominal wall lesion	5.80	NA	3.87	0.60	NA	10.27	090
23000	.....	A	Removal of calcium deposits	4.36	5.42	5.20	0.47	10.25	10.03	090
23020	.....	A	Release shoulder joint	8.93	NA	8.38	1.09	NA	18.40	090
23030	.....	A	Drain shoulder lesion	3.43	3.56	3.34	0.35	7.34	7.12	010
23031	.....	A	Drain shoulder bursa	2.74	3.26	3.12	0.05	6.05	5.91	010
23035	.....	A	Drain shoulder bone lesion	8.61	NA	11.29	1.04	NA	20.94	090
23040	.....	A	Exploratory shoulder surgery	9.20	NA	9.44	1.47	NA	20.11	090
23044	.....	A	Exploratory shoulder surgery	7.12	NA	7.98	1.18	NA	16.28	090
23065	.....	A	Biopsy shoulder tissues	2.27	2.22	1.28	0.09	4.58	3.64	010
23066	.....	A	Biopsy shoulder tissues	4.16	4.62	4.33	0.10	8.88	8.59	090
23075	.....	A	Removal of shoulder lesion	2.39	2.93	2.25	0.29	5.61	4.93	010
23076	.....	A	Removal of shoulder lesion	7.63	NA	6.07	0.65	NA	14.35	090
23077	.....	A	Remove tumor of shoulder	16.09	NA	11.47	1.38	NA	28.94	090
23100	.....	A	Biopsy of shoulder joint	6.03	NA	6.40	1.24	NA	13.67	090
23101	.....	A	Shoulder joint surgery	5.58	NA	6.34	1.21	NA	13.13	090
23105	.....	A	Remove shoulder joint lining	8.23	NA	7.89	1.73	NA	17.85	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
23106	.....	A	Incision of collarbone joint	5.96	NA	6.22	0.80	NA	12.98	090
23107	.....	A	Explore,treat shoulder joint	8.62	NA	8.13	1.60	NA	18.35	090
23120	.....	A	Partial removal, collar bone	7.11	NA	7.35	0.74	NA	15.20	090
23125	.....	A	Removal of collarbone	9.39	NA	8.49	1.27	NA	19.15	090
23130	.....	A	Partial removal, shoulderbone	7.55	NA	7.61	1.14	NA	16.30	090
23140	.....	A	Removal of bone lesion	6.89	NA	5.98	0.73	NA	13.60	090
23145	.....	A	Removal of bone lesion	9.09	NA	8.41	1.33	NA	18.83	090
23146	.....	A	Removal of bone lesion	7.83	NA	17.31	1.01	NA	26.15	090
23150	.....	A	Removal of humerus lesion	8.48	NA	7.89	1.01	NA	17.38	090
23155	.....	A	Removal of humerus lesion	10.35	NA	9.85	1.37	NA	21.57	090
23156	.....	A	Removal of humerus lesion	8.68	NA	8.40	1.25	NA	18.33	090
23170	.....	A	Remove collarbone lesion	6.86	NA	7.68	0.78	NA	15.32	090
23172	.....	A	Remove shoulder blade lesion	6.90	NA	7.76	0.73	NA	15.39	090
23174	.....	A	Remove humerus lesion	9.51	NA	9.23	1.21	NA	19.95	090
23180	.....	A	Remove collar bone lesion	8.53	NA	11.46	0.67	NA	20.66	090
23182	.....	A	Remove shoulder blade lesion	8.15	NA	10.95	1.13	NA	20.23	090
23184	.....	A	Remove humerus lesion	9.38	NA	12.03	1.48	NA	22.89	090
23190	.....	A	Partial removal of scapula	7.24	NA	6.52	0.98	NA	14.74	090
23195	.....	A	Removal of head of humerus	9.81	NA	8.88	1.45	NA	20.14	090
23200	.....	A	Removal of collar bone	12.08	NA	9.81	1.26	NA	23.15	090
23210	.....	A	Removal of shoulderblade	12.49	NA	10.38	1.41	NA	24.28	090
23220	.....	A	Partial removal of humerus	14.56	NA	12.42	2.03	NA	29.01	090
23221	.....	A	Partial removal of humerus	17.74	NA	13.26	1.19	NA	32.19	090
23222	.....	A	Partial removal of humerus	23.92	NA	17.77	2.30	NA	43.99	090
23330	.....	A	Remove shoulder foreign body	1.85	3.00	2.14	0.07	4.92	4.06	010
23331	.....	A	Remove shoulder foreign body	7.38	NA	7.54	0.38	NA	15.30	090
23332	.....	A	Remove shoulder foreign body	11.62	NA	10.00	1.57	NA	23.19	090
23350	.....	A	Injection for shoulder x-ray	1.00	7.27	0.32	0.05	8.32	1.37	000
23395	.....	A	Muscle transfer, shoulder/arm	16.85	NA	12.50	1.84	NA	31.19	090
23397	.....	A	Muscle transfers	16.13	NA	12.69	2.34	NA	31.16	090
23400	.....	A	Fixation of shoulder blade	13.54	NA	11.05	1.68	NA	26.27	090
23405	.....	A	Incision of tendon & muscle	8.37	NA	7.26	0.99	NA	16.62	090
23406	.....	A	Incise tendon(s) & muscle(s)	10.79	NA	9.63	1.58	NA	22.00	090
23410	.....	A	Repair of tendon(s)	12.45	NA	10.34	1.75	NA	24.54	090
23412	.....	A	Repair of tendon(s)	13.31	NA	10.87	2.16	NA	26.34	090
23415	.....	A	Release of shoulder ligament	9.97	NA	8.38	0.83	NA	19.18	090
23420	.....	A	Repair of shoulder	13.30	NA	11.39	2.34	NA	27.03	090
23430	.....	A	Repair biceps tendon	9.98	NA	8.91	1.19	NA	20.08	090
23440	.....	A	Removal/transplant tendon	10.48	NA	9.31	1.17	NA	20.96	090
23450	.....	A	Repair shoulder capsule	13.40	NA	10.73	2.04	NA	26.17	090
23455	.....	A	Repair shoulder capsule	14.37	NA	11.51	2.50	NA	28.38	090
23460	.....	A	Repair shoulder capsule	15.37	NA	6.49	2.24	NA	24.10	090
23462	.....	A	Repair shoulder capsule	15.30	NA	12.08	2.48	NA	29.86	090
23465	.....	A	Repair shoulder capsule	15.85	NA	12.50	2.27	NA	30.62	090
23466	.....	A	Repair shoulder capsule	14.22	NA	11.54	2.67	NA	28.43	090
23470	.....	A	Reconstruct shoulder joint	17.15	NA	13.00	2.65	NA	32.80	090
23472	.....	A	Reconstruct shoulder joint	16.92	NA	13.09	4.89	NA	34.90	090
23480	.....	A	Revision of collarbone	11.18	NA	9.78	1.02	NA	21.98	090
23485	.....	A	Revision of collar bone	13.43	NA	11.19	1.87	NA	26.49	090
23490	.....	A	Reinforce clavicle	11.86	NA	9.43	0.80	NA	22.09	090
23491	.....	A	Reinforce shoulder bones	14.21	NA	11.56	2.11	NA	27.88	090
23500	.....	A	Treat clavicle fracture	2.08	2.63	1.61	0.21	4.92	3.90	090
23505	.....	A	Treat clavicle fracture	3.69	4.24	3.17	0.38	8.31	7.24	090
23515	.....	A	Repair clavicle fracture	7.41	NA	6.65	1.12	NA	15.18	090
23520	.....	A	Treat clavicle dislocation	2.16	2.54	1.82	0.19	4.89	4.17	090
23525	.....	A	Treat clavicle dislocation	3.60	4.07	3.00	0.27	7.94	6.87	090
23530	.....	A	Repair clavicle dislocation	7.31	NA	5.55	0.91	NA	13.77	090
23532	.....	A	Repair clavicle dislocation	8.01	NA	7.16	1.19	NA	16.36	090
23540	.....	A	Treat clavicle dislocation	2.23	3.04	1.43	0.19	5.46	3.85	090
23545	.....	A	Treat clavicle dislocation	3.25	3.55	2.57	0.29	7.09	6.11	090
23550	.....	A	Repair clavicle dislocation	7.24	NA	6.40	1.46	NA	15.10	090
23552	.....	A	Repair clavicle dislocation	8.45	NA	7.05	1.17	NA	16.67	090
23570	.....	A	Treat shoulderblade fracture	2.23	2.68	2.01	0.25	5.16	4.49	090
23575	.....	A	Treat shoulderblade fracture	4.06	4.54	3.46	0.43	9.03	7.95	090
23585	.....	A	Repair scapula fracture	8.96	NA	7.78	1.29	NA	18.03	090
23600	.....	A	Treat humerus fracture	2.93	4.15	2.57	0.43	7.51	5.93	090
23605	.....	A	Treat humerus fracture	4.87	6.21	5.13	0.76	11.84	10.76	090
23615	.....	A	Repair humerus fracture	9.35	NA	8.32	1.78	NA	19.45	090
23616	.....	A	Repair humerus fracture	21.27	NA	14.86	3.54	NA	39.67	090
23620	.....	A	Treat humerus fracture	2.40	3.85	2.21	0.46	6.71	5.07	090
23625	.....	A	Treat humerus fracture	3.93	5.44	4.29	0.60	9.97	8.82	090
23630	.....	A	Repair humerus fracture	7.35	NA	6.58	1.40	NA	15.33	090
23650	.....	A	Treat shoulder dislocation	3.39	3.73	1.91	0.24	7.36	5.54	090
23655	.....	A	Treat shoulder dislocation	4.57	NA	3.11	0.44	NA	8.12	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
23660	.....	A	Repair shoulder dislocation	7.49	NA	6.16	1.40	NA	15.05	090
23665	.....	A	Treat dislocation/fracture	4.47	5.60	4.59	0.51	10.58	9.57	090
23670	.....	A	Repair dislocation/fracture	7.90	NA	7.09	1.85	NA	16.84	090
23675	.....	A	Treat dislocation/fracture	6.05	6.66	5.56	0.61	13.32	12.22	090
23680	.....	A	Repair dislocation/fracture	10.06	NA	8.32	2.13	NA	20.51	090
23700	.....	A	Fixation of shoulder	2.52	NA	2.79	0.34	NA	5.65	010
23800	.....	A	Fusion of shoulder joint	14.16	NA	11.49	2.63	NA	28.28	090
23802	.....	A	Fusion of shoulder joint	16.60	NA	13.56	2.24	NA	32.40	090
23900	.....	A	Amputation of arm & girdle	19.72	NA	13.23	2.40	NA	35.35	090
23920	.....	A	Amputation at shoulder joint	14.61	NA	11.09	2.54	NA	28.24	090
23921	.....	A	Amputation follow-up surgery	5.49	6.05	4.83	0.74	12.28	11.06	090
23930	.....	A	Drainage of arm lesion	2.94	3.45	2.68	0.24	6.63	5.86	010
23931	.....	A	Drainage of arm bursa	1.79	3.20	2.61	0.11	5.10	4.51	010
23935	.....	A	Drain arm/elbow bone lesion	6.09	NA	8.88	0.78	NA	15.75	090
24000	.....	A	Exploratory elbow surgery	5.82	NA	5.29	1.44	NA	12.55	090
24006	.....	A	Release elbow joint	9.31	NA	7.32	1.17	NA	17.80	090
24065	.....	A	Biopsy arm/elbow soft tissue	2.08	2.91	2.19	0.10	5.09	4.37	010
24066	.....	A	Biopsy arm/elbow soft tissue	5.21	5.26	4.91	0.41	10.88	10.53	090
24075	.....	A	Remove arm/elbow lesion	3.92	4.47	3.94	0.35	8.74	8.21	090
24076	.....	A	Remove arm/elbow lesion	6.30	NA	5.29	0.67	NA	12.26	090
24077	.....	A	Remove tumor of arm/elbow	11.76	NA	9.56	1.87	NA	23.19	090
24100	.....	A	Biopsy elbow joint lining	4.93	NA	4.41	0.69	NA	10.03	090
24101	.....	A	Explore/treat elbow joint	6.13	NA	5.48	1.41	NA	13.02	090
24102	.....	A	Remove elbow joint lining	8.03	NA	5.02	1.81	NA	14.86	090
24105	.....	A	Removal of elbow bursa	3.61	NA	3.83	0.63	NA	8.07	090
24110	.....	A	Remove humerus lesion	7.39	NA	7.38	1.22	NA	15.99	090
24115	.....	A	Remove/graft bone lesion	9.63	NA	9.08	1.33	NA	20.04	090
24116	.....	A	Remove/graft bone lesion	11.81	NA	10.34	1.47	NA	23.62	090
24120	.....	A	Remove elbow lesion	6.65	NA	5.69	0.98	NA	13.32	090
24125	.....	A	Remove/graft bone lesion	7.89	NA	6.71	0.61	NA	15.21	090
24126	.....	A	Remove/graft bone lesion	8.31	NA	5.16	1.21	NA	14.68	090
24130	.....	A	Removal of head of radius	6.25	NA	5.61	1.08	NA	12.94	090
24134	.....	A	Removal of arm bone lesion	9.73	NA	11.90	1.24	NA	22.87	090
24136	.....	A	Remove radius bone lesion	7.99	NA	5.46	0.92	NA	14.37	090
24138	.....	A	Remove elbow bone lesion	8.05	NA	6.86	1.06	NA	15.97	090
24140	.....	A	Partial removal of arm bone	9.18	NA	12.04	1.45	NA	22.67	090
24145	.....	A	Partial removal of radius	7.58	NA	8.91	1.03	NA	17.52	090
24147	.....	A	Partial removal of elbow	7.54	NA	8.68	1.08	NA	17.30	090
24149	.....	A	Radical resection of elbow	14.20	NA	9.65	2.07	NA	25.92	090
24150	.....	A	Extensive humerus surgery	13.27	NA	11.56	2.24	NA	27.07	090
24151	.....	A	Extensive humerus surgery	15.58	NA	12.80	2.11	NA	30.49	090
24152	.....	A	Extensive radius surgery	10.06	NA	8.54	1.16	NA	19.76	090
24153	.....	A	Extensive radius surgery	11.54	NA	6.20	1.71	NA	19.45	090
24155	.....	A	Removal of elbow joint	11.73	NA	8.35	1.72	NA	21.80	090
24160	.....	A	Remove elbow joint implant	7.83	NA	6.62	0.80	NA	15.25	090
24164	.....	A	Remove radius head implant	6.23	NA	5.52	0.90	NA	12.65	090
24200	.....	A	Removal of arm foreign body	1.76	2.87	1.96	0.06	4.69	3.78	010
24201	.....	A	Removal of arm foreign body	4.56	5.46	4.53	0.49	10.51	9.58	090
24220	.....	A	Injection for elbow x-ray	1.31	8.29	0.43	0.05	9.65	1.79	000
24301	.....	A	Muscle/tendon transfer	10.20	NA	7.76	1.23	NA	19.19	090
24305	.....	A	Arm tendon lengthening	7.45	NA	6.23	0.29	NA	13.97	090
24310	.....	A	Revision of arm tendon	5.98	NA	6.20	0.48	NA	12.66	090
24320	.....	A	Repair of arm tendon	10.56	NA	7.53	1.29	NA	19.38	090
24330	.....	A	Revision of arm muscles	9.60	NA	7.25	1.43	NA	18.28	090
24331	.....	A	Revision of arm muscles	10.65	NA	8.39	1.57	NA	20.61	090
24340	.....	A	Repair of biceps tendon	7.89	NA	6.50	1.13	NA	15.52	090
24341	.....	A	Repair tendon/muscle arm	7.90	NA	6.57	1.14	NA	15.61	090
24342	.....	A	Repair of ruptured tendon	10.62	NA	8.13	1.76	NA	20.51	090
24350	.....	A	Repair of tennis elbow	5.25	NA	4.97	0.69	NA	10.91	090
24351	.....	A	Repair of tennis elbow	5.91	NA	5.44	0.73	NA	12.08	090
24352	.....	A	Repair of tennis elbow	6.43	NA	5.76	0.93	NA	13.12	090
24354	.....	A	Repair of tennis elbow	6.48	NA	5.81	0.94	NA	13.23	090
24356	.....	A	Revision of tennis elbow	6.68	NA	5.85	1.18	NA	13.71	090
24360	.....	A	Reconstruct elbow joint	12.34	NA	9.03	2.47	NA	23.84	090
24361	.....	A	Reconstruct elbow joint	14.08	NA	10.28	2.00	NA	26.36	090
24362	.....	A	Reconstruct elbow joint	14.99	NA	8.91	0.80	NA	24.70	090
24363	.....	A	Replace elbow joint	18.49	NA	12.86	4.13	NA	35.48	090
24365	.....	A	Reconstruct head of radius	8.39	NA	6.95	1.19	NA	16.53	090
24366	.....	A	Reconstruct head of radius	9.13	NA	7.19	1.80	NA	18.12	090
24400	.....	A	Revision of humerus	11.06	NA	10.14	1.37	NA	22.57	090
24410	.....	A	Revision of humerus	14.82	NA	11.94	2.06	NA	28.82	090
24420	.....	A	Revision of humerus	13.44	NA	13.08	2.01	NA	28.53	090
24430	.....	A	Repair of humerus	12.81	NA	10.71	2.34	NA	25.86	090
24435	.....	A	Repair humerus with graft	13.17	NA	11.46	2.84	NA	27.47	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
24470	.....	A	Revision of elbow joint	8.74	NA	4.63	1.30	NA	14.67	090
24495	.....	A	Decompression of forearm	8.12	NA	7.31	1.10	NA	16.53	090
24498	.....	A	Reinforce humerus	11.92	NA	10.21	1.62	NA	23.75	090
24500	.....	A	Treat humerus fracture	3.21	5.47	2.28	0.36	9.04	5.85	090
24505	.....	A	Treat humerus fracture	5.17	8.36	5.37	0.71	14.24	11.25	090
24515	.....	A	Repair humerus fracture	11.65	NA	9.55	1.54	NA	22.74	090
24516	.....	A	Repair humerus fracture	11.65	NA	9.97	1.54	NA	23.16	090
24530	.....	A	Treat humerus fracture	3.50	6.29	3.38	0.42	10.21	7.30	090
24535	.....	A	Treat humerus fracture	6.87	8.76	5.80	0.78	16.41	13.45	090
24538	.....	A	Treat humerus fracture	9.43	NA	8.63	1.26	NA	19.32	090
24545	.....	A	Repair humerus fracture	10.46	NA	8.63	1.59	NA	20.68	090
24546	.....	A	Repair humerus fracture	15.69	NA	11.88	1.59	NA	29.16	090
24560	.....	A	Treat humerus fracture	2.80	5.22	1.84	0.30	8.32	4.94	090
24565	.....	A	Treat humerus fracture	5.56	7.80	4.89	0.54	13.90	10.99	090
24566	.....	A	Treat humerus fracture	7.79	NA	7.72	0.96	NA	16.47	090
24575	.....	A	Repair humerus fracture	10.66	NA	7.63	1.24	NA	19.53	090
24576	.....	A	Treat humerus fracture	2.86	5.19	2.32	0.33	8.38	5.51	090
24577	.....	A	Treat humerus fracture	5.79	8.10	5.13	0.61	14.50	11.53	090
24579	.....	A	Repair humerus fracture	11.60	NA	9.50	1.35	NA	22.45	090
24582	.....	A	Treat humerus fracture	8.55	NA	7.95	1.06	NA	17.56	090
24586	.....	A	Repair elbow fracture	15.21	NA	10.29	2.36	NA	27.86	090
24587	.....	A	Repair elbow fracture	15.16	NA	10.16	2.17	NA	27.49	090
24600	.....	A	Treat elbow dislocation	4.23	6.87	3.19	0.26	11.36	7.68	090
24605	.....	A	Treat elbow dislocation	5.42	NA	4.19	0.37	NA	9.98	090
24615	.....	A	Repair elbow dislocation	9.42	NA	7.03	1.48	NA	17.93	090
24620	.....	A	Treat elbow fracture	6.98	NA	5.53	0.57	NA	13.08	090
24635	.....	A	Repair elbow fracture	13.19	NA	17.15	1.78	NA	32.12	090
24640	.....	A	Treat elbow dislocation	1.20	3.49	0.77	0.08	4.77	2.05	010
24650	.....	A	Treat radius fracture	2.16	4.93	1.72	0.33	7.42	4.21	090
24655	.....	A	Treat radius fracture	4.40	7.15	4.13	0.45	12.00	8.98	090
24665	.....	A	Repair radius fracture	8.14	NA	7.41	1.14	NA	16.69	090
24666	.....	A	Repair radius fracture	9.49	NA	8.31	1.60	NA	19.40	090
24670	.....	A	Treatment of ulna fracture	2.54	4.99	2.09	0.27	7.80	4.90	090
24675	.....	A	Treatment of ulna fracture	4.72	7.44	4.48	0.54	12.70	9.74	090
24685	.....	A	Repair ulna fracture	8.80	NA	7.82	1.34	NA	17.96	090
24800	.....	A	Fusion of elbow joint	11.20	NA	8.22	1.55	NA	20.97	090
24802	.....	A	Fusion/graft of elbow joint	13.69	NA	10.51	1.99	NA	26.19	090
24900	.....	A	Amputation of upper arm	9.60	NA	8.14	1.39	NA	19.13	090
24920	.....	A	Amputation of upper arm	9.54	NA	9.61	1.19	NA	20.34	090
24925	.....	A	Amputation follow-up surgery	7.07	NA	6.11	0.75	NA	13.93	090
24930	.....	A	Amputation follow-up surgery	10.25	NA	9.60	1.17	NA	21.02	090
24931	.....	A	Amputate upper arm & implant	12.72	NA	11.49	1.84	NA	26.05	090
24935	.....	A	Revision of amputation	15.56	NA	10.07	2.24	NA	27.87	090
25000	.....	A	Incision of tendon sheath	3.38	NA	5.29	0.62	NA	9.29	090
25020	.....	A	Decompression of forearm	5.92	NA	7.99	0.77	NA	14.68	090
25023	.....	A	Decompression of forearm	12.96	NA	13.16	0.94	NA	27.06	090
25028	.....	A	Drainage of forearm lesion	5.25	NA	6.95	0.36	NA	12.56	090
25031	.....	A	Drainage of forearm bursa	4.14	NA	6.81	0.09	NA	11.04	090
25035	.....	A	Treat forearm bone lesion	7.36	NA	11.52	1.01	NA	19.89	090
25040	.....	A	Explore/treat wrist joint	7.18	NA	7.45	0.90	NA	15.53	090
25065	.....	A	Biopsy forearm soft tissues	1.99	1.90	2.55	0.09	3.98	4.63	010
25066	.....	A	Biopsy forearm soft tissues	4.13	NA	6.13	0.22	NA	10.48	090
25075	.....	A	Removal of forearm lesion	3.74	NA	5.14	0.37	NA	9.25	090
25076	.....	A	Removal of forearm lesion	4.92	NA	8.53	0.67	NA	14.12	090
25077	.....	A	Remove tumor, forearm/wrist	9.76	NA	10.69	1.67	NA	22.12	090
25085	.....	A	Incision of wrist capsule	5.50	NA	7.81	0.71	NA	14.02	090
25100	.....	A	Biopsy of wrist joint	3.90	NA	5.49	0.79	NA	10.18	090
25101	.....	A	Explore/treat wrist joint	4.69	NA	5.99	0.98	NA	11.66	090
25105	.....	A	Remove wrist joint lining	5.85	NA	8.15	1.19	NA	15.19	090
25107	.....	A	Remove wrist joint cartilage	6.43	NA	8.52	0.89	NA	15.84	090
25110	.....	A	Remove wrist tendon lesion	3.92	NA	5.83	0.46	NA	10.21	090
25111	.....	A	Remove wrist tendon lesion	3.39	NA	4.52	0.55	NA	8.46	090
25112	.....	A	Reremove wrist tendon lesion	4.53	NA	5.26	0.66	NA	10.45	090
25115	.....	A	Remove wrist/forearm lesion	8.82	NA	11.76	1.23	NA	21.81	090
25116	.....	A	Remove wrist/forearm lesion	7.11	NA	10.94	1.38	NA	19.43	090
25118	.....	A	Excise wrist tendon sheath	4.37	NA	5.83	1.02	NA	11.22	090
25119	.....	A	Partial removal of ulna	6.04	NA	8.38	1.32	NA	15.74	090
25120	.....	A	Removal of forearm lesion	6.10	NA	10.24	1.14	NA	17.48	090
25125	.....	A	Remove/graft forearm lesion	7.48	NA	10.82	1.04	NA	19.34	090
25126	.....	A	Remove/graft forearm lesion	7.55	NA	11.84	1.12	NA	20.51	090
25130	.....	A	Removal of wrist lesion	5.26	NA	6.41	0.67	NA	12.34	090
25135	.....	A	Remove & graft wrist lesion	6.89	NA	7.29	0.97	NA	15.15	090
25136	.....	A	Remove & graft wrist lesion	5.97	NA	6.61	0.85	NA	13.43	090
25145	.....	A	Remove forearm bone lesion	6.37	NA	10.24	0.75	NA	17.36	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
25150	.....	A	Partial removal of ulna	7.09	NA	8.99	1.12	NA	17.20	090
25151	.....	A	Partial removal of radius	7.39	NA	11.22	1.02	NA	19.63	090
25170	.....	A	Extensive forearm surgery	11.09	NA	12.78	1.51	NA	25.38	090
25210	.....	A	Removal of wrist bone	5.95	NA	6.68	0.80	NA	13.43	090
25215	.....	A	Removal of wrist bones	7.89	NA	9.32	1.42	NA	18.63	090
25230	.....	A	Partial removal of radius	5.23	NA	6.38	0.85	NA	12.46	090
25240	.....	A	Partial removal of ulna	5.17	NA	7.82	0.86	NA	13.85	090
25246	.....	A	Injection for wrist x-ray	1.45	8.10	0.47	0.05	9.60	1.97	000
25248	.....	A	Remove forearm foreign body	5.14	NA	6.89	0.37	NA	12.40	090
25250	.....	A	Removal of wrist prosthesis	6.60	NA	7.13	0.91	NA	14.64	090
25251	.....	A	Removal of wrist prosthesis	9.57	NA	10.66	1.39	NA	21.62	090
25260	.....	A	Repair forearm tendon/muscle	7.80	NA	11.24	0.78	NA	19.82	090
25263	.....	A	Repair forearm tendon/muscle	7.82	NA	10.83	1.03	NA	19.68	090
25265	.....	A	Repair forearm tendon/muscle	9.88	NA	12.92	1.41	NA	24.21	090
25270	.....	A	Repair forearm tendon/muscle	6.00	NA	10.35	0.55	NA	16.90	090
25272	.....	A	Repair forearm tendon/muscle	7.04	NA	10.95	0.54	NA	18.53	090
25274	.....	A	Repair forearm tendon/muscle	8.75	NA	11.62	1.13	NA	21.50	090
25280	.....	A	Revise wrist/forearm tendon	7.22	NA	11.21	0.69	NA	19.12	090
25290	.....	A	Incise wrist/forearm tendon	5.29	NA	12.04	0.41	NA	17.74	090
25295	.....	A	Release wrist/forearm tendon	6.55	NA	9.86	0.52	NA	16.93	090
25300	.....	A	Fusion of tendons at wrist	8.80	NA	8.20	1.19	NA	18.19	090
25301	.....	A	Fusion of tendons at wrist	8.40	NA	7.92	1.18	NA	17.50	090
25310	.....	A	Transplant forearm tendon	8.14	NA	11.53	1.17	NA	20.84	090
25312	.....	A	Transplant forearm tendon	9.57	NA	12.17	1.31	NA	23.05	090
25315	.....	A	Revise palsy hand tendon(s)	10.20	NA	13.02	1.34	NA	24.56	090
25316	.....	A	Revise palsy hand tendon(s)	12.33	NA	14.28	1.78	NA	28.39	090
25320	.....	A	Repair/revise wrist joint	10.77	NA	9.55	1.45	NA	21.77	090
25332	.....	A	Revise wrist joint	11.41	NA	9.84	1.61	NA	22.86	090
25335	.....	A	Realignment of hand	12.88	NA	12.17	1.56	NA	26.61	090
25337	.....	A	Reconstruct ulna/radioulnar	10.17	NA	10.87	1.45	NA	22.49	090
25350	.....	A	Revision of radius	8.78	NA	11.95	1.26	NA	21.99	090
25355	.....	A	Revision of radius	10.17	NA	12.54	1.49	NA	24.20	090
25360	.....	A	Revision of ulna	8.43	NA	11.72	0.99	NA	21.14	090
25365	.....	A	Revise radius & ulna	12.40	NA	13.58	1.57	NA	27.55	090
25370	.....	A	Revise radius or ulna	13.36	NA	15.03	1.92	NA	30.31	090
25375	.....	A	Revise radius & ulna	13.04	NA	14.84	0.87	NA	28.75	090
25390	.....	A	Shorten radius/ulna	10.40	NA	13.14	1.50	NA	25.04	090
25391	.....	A	Lengthen radius/ulna	13.65	NA	14.69	1.93	NA	30.27	090
25392	.....	A	Shorten radius & ulna	13.95	NA	13.19	2.04	NA	29.18	090
25393	.....	A	Lengthen radius & ulna	15.87	NA	16.01	2.32	NA	34.20	090
25400	.....	A	Repair radius or ulna	10.92	NA	13.41	1.75	NA	26.08	090
25405	.....	A	Repair/graft radius or ulna	14.38	NA	15.51	2.02	NA	31.91	090
25415	.....	A	Repair radius & ulna	13.35	NA	14.84	1.92	NA	30.11	090
25420	.....	A	Repair/graft radius & ulna	16.33	NA	16.41	2.28	NA	35.02	090
25425	.....	A	Repair/graft radius or ulna	13.21	NA	19.06	1.87	NA	34.14	090
25426	.....	A	Repair/graft radius & ulna	15.82	NA	15.54	2.13	NA	33.49	090
25440	.....	A	Repair/graft wrist bone	10.44	NA	9.35	1.50	NA	21.29	090
25441	.....	A	Reconstruct wrist joint	12.90	NA	10.57	1.89	NA	25.36	090
25442	.....	A	Reconstruct wrist joint	10.85	NA	9.78	1.22	NA	21.85	090
25443	.....	A	Reconstruct wrist joint	10.39	NA	11.14	1.52	NA	23.05	090
25444	.....	A	Reconstruct wrist joint	11.15	NA	11.18	1.66	NA	23.99	090
25445	.....	A	Reconstruct wrist joint	9.69	NA	10.54	1.72	NA	21.95	090
25446	.....	A	Wrist replacement	16.55	NA	12.82	3.49	NA	32.86	090
25447	.....	A	Repair wrist joint(s)	10.37	NA	9.41	1.56	NA	21.34	090
25449	.....	A	Remove wrist joint implant	14.49	NA	13.45	1.16	NA	29.10	090
25450	.....	A	Revision of wrist joint	7.87	NA	6.29	1.19	NA	15.35	090
25455	.....	A	Revision of wrist joint	9.49	NA	12.73	1.42	NA	23.64	090
25490	.....	A	Reinforce radius	9.54	NA	12.48	1.42	NA	23.44	090
25491	.....	A	Reinforce ulna	9.96	NA	12.22	1.49	NA	23.67	090
25492	.....	A	Reinforce radius and ulna	12.33	NA	14.20	1.84	NA	28.37	090
25500	.....	A	Treat fracture of radius	2.45	4.50	1.75	0.29	7.24	4.49	090
25505	.....	A	Treat fracture of radius	5.21	7.56	4.57	0.51	13.28	10.29	090
25515	.....	A	Repair fracture of radius	9.18	NA	8.04	1.22	NA	18.44	090
25520	.....	A	Repair fracture of radius	6.26	7.33	5.16	0.94	14.53	12.36	090
25525	.....	A	Repair fracture of radius	12.24	NA	9.89	1.83	NA	23.96	090
25526	.....	A	Repair fracture of radius	12.98	NA	14.96	1.94	NA	29.88	090
25530	.....	A	Treat fracture of ulna	2.09	4.66	1.88	0.35	7.10	4.32	090
25535	.....	A	Treat fracture of ulna	5.14	7.62	4.56	0.54	13.30	10.24	090
25545	.....	A	Repair fracture of ulna	8.90	NA	7.87	1.20	NA	17.97	090
25560	.....	A	Treat fracture radius & ulna	2.44	4.72	1.52	0.27	7.43	4.23	090
25565	.....	A	Treat fracture radius & ulna	5.63	7.84	4.83	0.70	14.17	11.16	090
25574	.....	A	Treat fracture radius & ulna	7.01	NA	6.77	1.73	NA	15.51	090
25575	.....	A	Repair fracture radius/ulna	10.45	NA	8.74	1.73	NA	20.92	090
25600	.....	A	Treat fracture radius/ulna	2.63	5.04	1.96	0.42	8.09	5.01	090

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ADDENDUM C.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility practice expense RVUs	Facility practice expense RVUs	Mal-practice RVUs	Non-facility total	Facility total	Global
25605	.....	A	Treat fracture radius/ulna	5.81	8.09	5.07	0.61	14.51	11.49	090
25611	.....	A	Repair fracture radius/ulna	7.77	NA	7.72	0.97	NA	16.46	090
25620	.....	A	Repair fracture radius/ulna	8.55	NA	7.68	1.14	NA	17.37	090
25622	.....	A	Treat wrist bone fracture	2.61	4.94	1.89	0.33	7.88	4.83	090
25624	.....	A	Treat wrist bone fracture	4.53	7.20	4.03	0.57	12.30	9.13	090
25628	.....	A	Repair wrist bone fracture	8.43	NA	7.54	1.16	NA	17.13	090
25630	.....	A	Treat wrist bone fracture	2.88	5.15	1.89	0.30	8.33	5.07	090
25635	.....	A	Treat wrist bone fracture	4.39	7.04	2.65	0.50	11.93	7.54	090
25645	.....	A	Repair wrist bone fracture	7.25	NA	6.63	0.95	NA	14.83	090
25650	.....	A	Repair wrist bone fracture	3.05	5.07	1.85	0.36	8.48	5.26	090
25660	.....	A	Treat wrist dislocation	4.76	NA	3.77	0.26	NA	8.79	090
25670	.....	A	Repair wrist dislocation	7.92	NA	7.24	1.12	NA	16.28	090
25675	.....	A	Treat wrist dislocation	4.67	6.88	3.73	0.34	11.89	8.74	090
25676	.....	A	Repair wrist dislocation	8.04	NA	7.31	1.11	NA	16.46	090
25680	.....	A	Treat wrist fracture	5.99	NA	4.82	0.36	NA	11.17	090
25685	.....	A	Repair wrist fracture	9.78	NA	8.08	1.44	NA	19.30	090
25690	.....	A	Treat wrist dislocation	5.50	NA	5.30	0.73	NA	11.53	090
25695	.....	A	Repair wrist dislocation	8.34	NA	7.53	1.17	NA	17.04	090
25800	.....	A	Fusion of wrist joint	9.76	NA	9.00	1.80	NA	20.56	090
25805	.....	A	Fusion/graft of wrist joint	11.28	NA	9.89	2.09	NA	23.26	090
25810	.....	A	Fusion/graft of wrist joint	10.57	NA	9.51	2.06	NA	22.14	090
25820	.....	A	Fusion of hand bones	7.45	NA	7.22	1.48	NA	16.15	090
25825	.....	A	Fusion hand bones with graft	9.27	NA	8.75	1.99	NA	20.01	090
25830	.....	A	Fusion radioulnar jnt/ulna	10.06	NA	12.33	1.45	NA	23.84	090
25900	.....	A	Amputation of forearm	9.01	NA	10.20	1.31	NA	20.52	090
25905	.....	A	Amputation of forearm	9.12	NA	10.56	1.15	NA	20.83	090
25907	.....	A	Amputation follow-up surgery	7.80	NA	9.44	1.00	NA	18.24	090
25909	.....	A	Amputation follow-up surgery	8.96	NA	9.25	1.06	NA	19.27	090
25915	.....	A	Amputation of forearm	17.08	NA	27.86	2.59	NA	47.53	090
25920	.....	A	Amputate hand at wrist	8.68	NA	7.64	1.20	NA	17.52	090
25922	.....	A	Amputate hand at wrist	7.42	NA	8.39	1.02	NA	16.83	090
25924	.....	A	Amputation follow-up surgery	8.46	NA	6.74	1.22	NA	16.42	090
25927	.....	A	Amputation of hand	8.80	NA	9.39	1.22	NA	19.41	090
25929	.....	A	Amputation follow-up surgery	7.59	NA	5.42	0.96	NA	13.97	090
25931	.....	A	Amputation follow-up surgery	7.81	NA	9.81	0.90	NA	18.52	090
26010	.....	A	Drainage of finger abscess	1.54	3.16	2.25	0.05	4.75	3.84	010
26011	.....	A	Drainage of finger abscess	2.19	4.46	4.45	0.24	6.89	6.88	010
26020	.....	A	Drain hand tendon sheath	4.67	NA	8.66	0.63	NA	13.96	090
26025	.....	A	Drainage of palm bursa	4.82	NA	8.82	0.76	NA	14.40	090
26030	.....	A	Drainage of palm bursa(s)	5.93	NA	9.38	0.98	NA	16.29	090
26034	.....	A	Treat hand bone lesion	6.23	NA	10.41	0.71	NA	17.35	090
26035	.....	A	Decompress fingers/hand	9.51	NA	11.92	0.86	NA	22.29	090
26037	.....	A	Decompress fingers/hand	7.25	NA	7.75	1.05	NA	16.05	090
26040	.....	A	Release palm contracture	3.33	NA	7.99	0.49	NA	11.81	090
26045	.....	A	Release palm contracture	5.56	NA	9.39	0.81	NA	15.76	090
26055	.....	A	Incise finger tendon sheath	2.69	5.15	8.67	0.56	8.40	11.92	090
26060	.....	A	Incision of finger tendon	2.81	NA	5.19	0.17	NA	8.17	090
26070	.....	A	Explore/treat hand joint	3.69	NA	7.33	0.42	NA	11.44	090
26075	.....	A	Explore/treat finger joint	3.79	NA	7.85	0.62	NA	12.26	090
26080	.....	A	Explore/treat finger joint	4.24	NA	8.63	0.51	NA	13.38	090
26100	.....	A	Biopsy hand joint lining	3.67	NA	5.43	0.45	NA	9.55	090
26105	.....	A	Biopsy finger joint lining	3.71	NA	8.19	0.67	NA	12.57	090
26110	.....	A	Biopsy finger joint lining	3.53	NA	7.67	0.50	NA	11.70	090
26115	.....	A	Removal of hand lesion	3.86	4.94	9.00	0.34	9.14	13.20	090
26116	.....	A	Removal of hand lesion	5.53	NA	9.13	0.62	NA	15.28	090
26117	.....	A	Remove tumor, hand/finger	8.55	NA	10.50	0.91	NA	19.96	090
26121	.....	A	Release palm contracture	7.54	NA	10.65	1.61	NA	19.80	090
26123	.....	A	Release palm contracture	9.29	NA	11.74	1.53	NA	22.56	090
26125	.....	A	Release palm contracture	4.61	NA	2.91	0.45	NA	7.97	ZZZ
26130	.....	A	Remove wrist joint lining	5.42	NA	10.50	0.86	NA	16.78	090
26135	.....	A	Revise finger joint, each	6.96	NA	11.26	0.82	NA	19.04	090
26140	.....	A	Revise finger joint, each	6.17	NA	10.68	0.75	NA	17.60	090
26145	.....	A	Tendon excision, palm/finger	6.32	NA	10.64	0.80	NA	17.76	090
26160	.....	A	Remove tendon sheath lesion	3.15	4.64	8.83	0.40	8.19	12.38	090
26170	.....	A	Removal of palm tendon, each	4.77	NA	6.08	0.45	NA	11.30	090
26180	.....	A	Removal of finger tendon	5.18	NA	6.32	0.71	NA	12.21	090
26185	.....	A	Remove finger bone	5.25	NA	11.35	0.41	NA	17.01	090
26200	.....	A	Remove hand bone lesion	5.51	NA	9.13	0.72	NA	15.36	090
26205	.....	A	Remove/graft bone lesion	7.70	NA	10.26	1.03	NA	18.99	090
26210	.....	A	Removal of finger lesion	5.15	NA	9.15	0.64	NA	14.94	090
26215	.....	A	Remove/graft finger lesion	7.10	NA	10.24	0.94	NA	18.28	090
26230	.....	A	Partial removal of hand bone	6.33	NA	9.17	0.69	NA	16.19	090
26235	.....	A	Partial removal, finger bone	6.19	NA	8.93	0.71	NA	15.83	090
26236	.....	A	Partial removal, finger bone	5.32	NA	8.66	0.66	NA	14.64	090

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